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CLINICAL LECTURE.

MATRIMONIAL STERILITY.

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Gentlemen:—English authors including Matthew Duncan, Sir Spencer Wells, Chas. West, and Marion Sims, of America, have shown by the statistics they have gathered that in England alone one marriage out of every eight is unfruitful. I have recently gathered similar statistics regarding the birth rate in Hamburg, and have found that out of 200 marriages among all classes 23 are unfruitful, which gives about the same proportion.

According to the researches of Kehrer, Duncan, Fürbringer, Noeggerath, Sänger, Prochownick, and others, the cause of this matrimonial barrenness must be laid at the door of the man in fully fifty per cent. of the cases, the main cause being the effects of past gonorrhoeas and their complications.

The subject of matrimonial sterility may be divided into two classes:

1. Matrimonial sterility caused by the wife.
2. Matrimonial sterility caused by the husband.

The unfruitfulness of the wife can (according to Kisch's division) be due to the following causes:

1. Incapability of germ formation.
2. Hinderance to the contact of the normal spermatozoa with the ovule.
3. Incapability of incubating the ovule.

Apart from deformities and tumors of the female genitals, all pathological changes of the ovaries, tubes, the uterus and its ligaments and peritoneal covering, must be taken into consideration. All diseases of these parts can either act as a direct hinderance to fecundation, or by means of their action upon the nutrition of the genital organs give rise to an incapability for conception, or, finally, check the incubation of the already fecundated ovule.

Apart from tumors, which necessitate a surgical operation, or syphilis which calls for a specific cure, the advised therapy of the diseases leading to, or causing sterility on the part of the wife, has been most varied, comprising "cures" and "treatment" at various health or bathing resorts, mineral baths, especially hip-baths, cauterization of the cervical and uterine canal, and the use of the curette, etc. Recent researches have disclosed the fact that cauterizations, especially when undertaken with concentrated chemicals, accomplish an end precisely opposite to that which we desire to obtain—viz., a contraction and atrophy of the endometrium. Even the oft undertaken and apparently simple operations of division of a narrow os, and curetting, have been proved by their results, not to be the harmless operations as they have heretofore been regarded.

Recently two curative methods have been adopted by gynecological therapeutics, which from their results may be regarded as the principal curative agents in female sterility. These are gynecological massage in connection with gynecological gymnastics as taught by Thure and Brandt, and gynecological electrotherapy as taught by Apostoli.

It is highly possibly that we can by means of massage reduce the swelling and decrease the painfulness of ovaries which have been rendered thickened and painful by oöphoritis and perioöphoritis, and gradually render the organs capable of fulfilling their normal functions. It is unquestionable that we are able by means of massage to restore to its normal condition a tube which has been rendered incapable of performing its normal functions, viz., the free passage of the spermatozoa to the ovule by perimetritic or salpingitic processes. Again, it has been abundantly proven that very frequently we can replace a uterus in its normal position after it has been retroflexed, bound down and apparently fixed by old parametric or perimetritic adhesions, thus rendering the possibility of conception far more probable. At all events, we can at least by means of massage bring about a healthier and more

normal condition of the uterus and adnexa. By means of a methodically applied massage therapy we also find that old chronic catarrhs of the uterus are curable, as well as erosions of the os. Surely for the cure of endometritis such a mild and inoffensive treatment is preferable to the use of strong chemical reagents and the curette, especially when the cure of sterility is the desired result for which we are striving. This is especially evident when we take into consideration that the latter methods of treatment frequently give rise to an eventual stenosis of the uterine canal or atrophy of the mucous membranes.

In all cases of faulty or incomplete development of the female genitalia, in cases of uterus infantilis and small ovaries, massage in connection with electricity promises the best results, and will in all probability render conception possible.

It will be seen, therefore, that massage is not only valuable in primary sterility of the female, but also in acquired sterility induced by disease, and especially in that form spoken of by English authors as "one child sterility" in which the severity of a primary childbirth or abortion has left a diseased or abnormal condition of the ovaries, tubes and uterus.

Another important point is that massage, in connection with the ichthyol treatment so highly spoken of by Freund, will cause a disappearance of the pain experienced during coitus, so frequently observed in these cases. Therefore, apart from the general benefit obtained, massage, in rendering sexual intercourse painless and therefore desirable, will, according to Duncan, Sims and Kirch, prove a most important factor in the complicated chain of requirements leading to conception.

Gynecological gymnastics, as taught by Thure Brandt, will prove a valuable auxiliary to massage in bringing about a normal condition of the generative organs.

As a proof of the value of massage in the treatment of acquired sterility, let me quote you the history of a case that came under my observation, and which I treated successfully with the assistance of Drs. von Engelhardt and Lomer at this Polyclinic.

The woman in question was 39 years of age, and married. She had borne two children; the last having been born fifteen years previously, at which time her lying-in period had been very tedious and accompanied by a great deal of fever. She applied on the fourth of September, 1889, for treatment, and upon examination it was found that she was suffering from a fixed

retroflexion of the uterus and endometritis. She was treated with massage only, and her condition became so improved that she soon ceased to visit the Polyclinic. Later she returned and the treatment was continued. In April, of 1891, she became pregnant, after a sterility of nearly eighteen years.

Gynecological electrotherapy, as taught by Apostoli, will often complete the beneficial effects produced by massage. Both the faradic as well as the constant current find their application. For instance, when parametritis or perimetritis is a prominent symptom the faradic current should be used, but when we have hæmorrhage with profuse catarrh of the endometrium, the constant current should be used intra-uterine. I would strongly suggest that unless there is a strong indication to the contrary, the negative electrode only should be used intra-uterine in the treatment of sterility.

This for the following reasons: First, the negative electrode exerts a mildly cauterizing action; second, it exerts a basic reaction in the uterine cavity, in opposition to the acid reaction of the positive pole. Since it has been proven that a basic or a weakly alkaline reaction forms a good ground or soil for the movements of the spermatozoa, the use of the negative pole would seem eminently applicable in such cases, to which Charriere has called attention, in which the utero-vaginal secretion is acid in its reaction. The beneficial action of vaginal irrigations with a 5 per cent. solution of phosphate of soda, so highly recommended by Charriere, can be considerably augmented by an electric treatment with the negative electrode.

Matrimonial sterility caused by the husband may be due to the following causes:

1. Impotentia coeundi.
2. Aspermatism.
3. Azöospermia.

Of these three causes of male impotency, the comparatively rare condition of impotentia coeundi, and the almost equally rare condition of aspermatism, we may pass these by and proceed to a consideration of azöospermia as the most frequent cause for sterility, or rather impotency, in the male.

Azöospermia, or a change in the ejaculatory fluid in which both quantitatively and qualitatively the semen is apparently normal, but in which the most important element, the spermatozoa are absent, can be caused by the following:

1. Stoppage of the vasa deferentia in consequence of inflammation or traumatism.

2. Nutritive disturbances of both testicles :

(a) occurring after funiculitis, epididymitis, and duplex orchitis ;

(b) from constitutional diseases, such as syphilis, tuberculosis, chronic alcoholism, diabetes mellitus, etc.;

(c) from varicocele, hydrocele, kryptorchismus.

3. Atrophy of the testicles :

(a) after sexual excesses ;

(b) after long indulgence in onanism ;

(c) after injury to certain parts of the brain, especially of the cerebellum.

The therapy of the azoospermia resulting from the majority of these diseases, namely those of a constitutional character, consists, naturally of a treatment of the general symptoms by well-known methods.

I will, therefore, restrict myself to a consideration of azoospermia as a result of duplex gonorrhœal epididymitis. Gosselin, in an article published in 1853, was the first to call attention to the influence of gonorrhœal epididymitis upon the generative potency of the male. The article then published was a most complete and exhaustive one. Gosselin's researches showed that an obliteration of the vasa deferentia at any part could result from inflammation whereby the product of the testicles would be retained from the seminal ejaculation ; the latter, however, being largely composed of the secretion from the prostate and Cowper's glands. One will also usually find at the side of the testicles, and frequently enclosing the vasa deferentia, a swelling or hardening, called globus gonorrhœicus by Gosselin, which usually is at the point of constriction of the vasa deferentia.

There exists but very little literature other than this concerning the pathological anatomy of gonorrhœal epididymitis. The chapter devoted to this subject in the majority of text-books usually treats of the pathological condition found on the autopsy table, and years after the cessation of causative inflammation. So, whether these conditions as found are the results of the original inflammation, or occur eventually as a result of the long continued functional disturbance, is difficult to say.

The action of gonorrhœal inflammations upon the testicles, epididymis, and vas is differently accepted by various authors. Whereas, for example, Zeisse considers that the inflammation of either the testicles or epididymis is an entirely harmless complication of gonorrhœa, Noeggerath, on the contrary, views with the utmost pessimism the future prospects of potency after an attack of double gonorrhœal epididymitis, and Für-

bringer has only lately said that it was his belief that a post-gonorrhœal inflammation of the testicles would eventually rob these organs of their function of producing spermatozoa.

Gosselin's opinion regarding the possibility of the constriction of the vas deferens becoming widened in the course of time, is in direct opposition to Fürbringer's views. For my part, I am of the belief that the pessimism of Fürbringer and Noeggerath in this direction goes somewhat too far, since a number of cases are known to almost every practitioner, in which after the patient has suffered from double epididymitis consecutive to gonorrhœa he has, nevertheless, been able to become subsequently the father of healthy children. Perchance the pessimism of the authors is due to the class of cases that have come under their experience, it being a curious fact that usually the most puzzling cases come to the notice of investigators.

As a result of extended clinical experiences, and pathological anatomical studies conducted at the old general hospital of this city, with the very kind assistance of Drs. Rast and Simmonds, I have been able to reach the following conclusions :

In gonorrhœal epididymitis with inflammation of the vas deferens and the epididymis we are also apparently dealing with a phlebitis and periphlebitis of the plexus pampiniformis, and also a lymphangitis of the lymphatics which are so extensive in these organs. The frequently observed occurrence of a continuation of the gonorrhœal process by an inflammation of the testicles, epididymis and vas deferens surely points to the probability that infection is carried to these parts by means of lymphatics, and the peri-vascular lymphatic spaces. Apart from this the hydrocele that nearly always exists in these cases, and the frequently stubborn varicocele of the plexus pampiniformis show that the vascular system is also greatly affected by the disease. In consequence of the inflammation of the vessels and inflammatory change that continues to exist, it is positive that the testicles cannot any longer receive the proper or requisite nutrition, and therefore are frequently not able to perform their normal functions. This becomes all the more positive when we remember how such a highly organized secretion as the human semen must be influenced by the nutritive condition of the organ which generates it. We see this frequently in syphilis, during the existence of which, as in cases of varicocele there exists an oligozoospermia, the seminal ejaculation containing but few

spermatozoa or if any these are perhaps with little or no vitality. While this does not point to an obliteration of the vasa deferentia it nevertheless confirms the theory of lack of nutrition of the testicles.

I would suggest that every case of gonorrhoeal epididymitis, with a view to the possible development of azoospermia, should be treated as early as possible to a systematic local treatment with massage in connection with ichthyol and permanent compression. I believe that by such a course of treatment we are able to retain or restore the nutrition to these parts, and cause an absorption of the inflammatory products.

For internal medication ichthyol is perhaps preferable to the much lauded iodide of potash, since preparations of iodine exert a deleterious action upon the production of semen. The technique of the massage is most simple, and consists in kneading and rubbing movements with the finger tips of one hand. Naturally, the sensitiveness of the organ must be taken into consideration, and the masseur should at first be very gentle, beginning with the massage of the testicles, then the epididymis, and finally the vas deferens. The cauda of the epididymis should receive especial attention, since at this there is a sharp bend in the vas deferens, and it is here also that after inflammatory processes, large quantities of lymphatic connective tissues may be found.

Ichthyol in the form of a five to ten per cent. ointment, made up with lanolin as a base, should be liberally applied to the scrotum every other day. In order to obtain permanent compression I have designed a suspensory bandage the bag of which is made of some impermeable material, elastic at the sides. By padding this bag with a thin layer of cotton, a very firm and comfortable bandage is obtained.

By these means we are enabled not only to successfully treat recent, but frequently also old cases of gonorrhoeal epididymitis.

HYPOSULPHITE OF SODA IN THE GRIPPE.

Dr. Ringk (*La Semaine médicale*, No. 59, 1891) asserts that the best remedy in the treatment of the grippe is the hyposulphite of soda, which, at the end of twenty-four hours, will produce a rapid retrogression of the symptoms. He employs it as a potion in the following formula:

R	Hyposulphite of soda.....	grammes 4.
	Distilled water.....	" 100.
	Raspberry syrup.....	" 20.
	A teaspoonful every one to three hours, according to the gravity of the case.	

RELAPSED HIP-JOINT DISEASE—DIAGNOSIS OF SPONDYLITIS.

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Delivered in the Jefferson Medical College Hospital.

RELAPSED HIP-JOINT DISEASE.

Gentlemen:—I shall bring before you this morning a case that should impart to you some important lessons if you will observe the principle points in reference to it. His family history is tuberculous. His brother had a double hip-joint disease, and upon him an excision was performed at this hospital, and another somewhere else. This patient four years ago had on the left side a tubercular osteitis which was treated on the conservative principle of immobilization, and a year ago the inflammatory symptoms of the hip had entirely subsided with no symptom of abscess. The case was in a most happy condition and had every prospect of having a useful leg, although there existed some fibrous restrictions to free motion. While playing with some boys, he says, his left leg became twisted, the partial ankylosis was probably broken at that time, and serious inflammation immediately followed. The patient comes here this morning with an abscess of the hip-joint as a direct result of the recent traumatism, and in a condition of relapse. The question as to the method of procedure is important. If dead bone exists, it must be removed either by operation or by absorption of the inflammatory process. There can be no doubt that there is dead bone here; shall we then proceed to excise the dead bone at the same time that we evacuate the abscess? If we do so we shall expose the freshly incised surfaces which are now healthy to the action of the tubercle bacilli, and thereby tend to a still further dissemination. Hence it would be best to wash out the cavity and get it into a good condition first; subsequently we may excise the dead bone with a greater assurance of success. The operation to-day will be simply that of incision of the skin to evacuate the abscess, and subsequently we shall treat the cavity. Extending over the trochanter on the left side, as you may see, is a large swelling, a fluctuating mass, attended with a dusky redness of the surface. It is

undoubtedly an abscess having its origin in the hip-joint. For the purpose of drainage I shall make two incisions, one where the fluctuation is most pronounced, and the other at the lowermost point of the abscess. I find that over the great trochanter is the seat of the most fluctuation, and here I make my first incision. You can see the fountain of purulent material which is escaping. Now by means of a long probe I shall examine the condition of the abscess cavity. About midway down the thigh I can feel the end of the probe, showing that the pocket has extended beneath the fascia and reached this point, at which I shall make a counter-opening in order that I may institute satisfactory drainage. Now I must ascertain the extent of dead bone involvement by means of a small probe. I find at once a curious condition of the head of the femur and acetabulum, which is softened so that I can almost push the probe through the neck. Having now thoroughly washed out the entire cavity with peroxide of hydrogen, I inject ten per cent. emulsion of iodoform in olive oil, insert drainage tube, and apply aseptic dressing. The patient will be put to bed and maintained in the correct position to avoid motion, the abscess cavity again thoroughly cleansed to-morrow, and when the flow of pus has subsided, further exploration will be resorted to. In the mean time the affected hip will be kept at rest to avoid the breaking down of the already softened bone.

DIAGNOSIS OF SPONDYLITIS—ILLUSTRATIVE CASES.

This morning I want to present to you some illustrative cases which will show you how to make a diagnosis in Potts' disease or spondylitis. The cases I shall bring before you this morning will illustrate the case as well as the difficulty in diagnosing spondylitis, depending upon the age of the case and stage of the disease. Some of the cases carry their diagnosis in such a plain manner that you cannot fail to tell what they are. There is no credit to anyone in making such a diagnosis after the hump is developed, for it is impossible then to fail; the difficulty lies in recognizing the disease in its incipient stage. A curious feature of spondylitis is that all of the pain and all of the nervous symptoms are such as to draw the attention to some other part of the body rather than to the real site of the disease. This same curious feature is noticed occasionally in hip-joint disease, where the trouble is frequently referred to the knee-joint. When there is pain in spondylitis, it is apt to be referred to differ-

ent portions of the body, as are also the nervous symptoms which are dependent upon the accompanying nervous disturbances. Then there is a dyspnoea associated with caries of the dorsal region. Also there may be an irritable condition of the bronchi or of the bladder, so that the disease will simulate a pneumonia, a bronchitis, or a cystitis, and, in fact, cases have come to my notice that have been treated for these conditions.

This little fellow carries his diagnosis with him in such a manner that it is unmistakable. The manner in which we left this child illustrates the care to be observed in lifting such cases. If we should lift him by the shoulders, we would allow the weight to hang upon the diseased portion of the vertebral column. As we lift the upper portion of the body, at the same time we raise the lower portion so as to disturb the existing relations about the focus of inflammation as little as possible.

The boy has a kyphosis involving the upper dorsal vertebrae due to tubercular caries. Just above the kyphosis is a bending in, which is a compensation to allow the weight of the child's head to be projected in as near as possible a straight line. The breast here is what is called "pigeon-breast," because it resembles the pointed angular condition found in pigeons and is due to the distortion of the ribs. As we examine the scapulae, in addition we find they are both very prominent, the angles standing out in an unnatural position. The ribs have changed position, and hence the scapulae are in this abnormal position. There is also a decided shortening of the trunk. If we were to take a curve of any kind, say one of whalebone, and straighten it out, the length of the curve would not be increased, but the distance between the ends of the curve would be greater when it was in a straight line. So here as the column curves the trunk becomes shortened. Below the diseased vertebrae the spine is straighter than the normal vertebral column. There is no trouble in this case in making our diagnosis, but the important thought is, was it possible to make the diagnosis in its incipency. This is the question I want you to solve for me this morning. As to the diagnosis with reference to the situation, or what is called the localization of the spinal lesions, that is a subject which will require careful consideration with suitable cases after you have become more familiar with the gross manifestations of the disease.

This next little fellow presents the following symptoms: There is a disinclination to lift the head, which constantly rests against

the mother's shoulder, as you may see. As I put my hands upon my hips in the position called "the arms akimbo," I can lift the weight of my head from the spine by muscular effort in a mechanical way. This is a position assumed by children often in their instinctive efforts to lift or relieve the weight from the carious spine. In addition this child has the characteristic rasping, grunting respiration which makes it possible to diagnose caries of the spine before the kyphosis presents itself. If you will fix your ribs and diaphragm firmly by muscular action with the desire not to move them, and then try to breathe, you will have the sound produced which is almost pathognomonic of caries of the vertebræ. Another point that shows the same thing is the rigidity of the muscles, and this is an early symptom dependent upon the child's efforts to avoid motion. As I hold the child in a prone condition on my lap I do so to overcome any muscular rigidity. If I hold him up in the sitting posture I feel his desire to have me hold his head, and I feel also the rigidity of the muscles of the chest. If I ask a child with a supposed caries of the spine to stoop and pick up an object from the floor, he will not stoop as a natural person will, curving his spine in the act, but will go through a *manœuvre*, that will keep the spine rigid, and go down sidewise by bending his knees and hips while feeling for the body with his hands. Another method, and one which is frequently preferred, is, the patient lying prone on a bed to take a child by the knees and raise the body gently sufficiently far to have the hips free from the table or bed. The spinal column instead of bending is held in a position of fixation and the curvature still shows itself in a slight degree. If I were to do this to the natural spine, the hips would arch up, and the arch would extend through the entire spinal column. The pain, when present, is generally present in the early hours of sleep, during the first two hours most markedly. This is due generally to the inflammatory exudate, and not to the pressure of bone upon nerve trunks or filaments, or it may be produced mechanically by muscular rigidity. The pain is seldom felt at the seat of the disease, but at some distance from the site of the caries. In this child it is possible by means of the fingers to follow up every spinal process above the seat of the disease; but at the site of the disease, the processes are all locked and massed together, while below they are distinct. Observe the rigidity and forced respiration in this girl which can be plainly seen by all of you in the motion

of the ribs, even if you cannot hear the respiration. The mechanical explanation of this I have given by explaining the effect of rigid muscular contraction, but it is not the only explanation given. Another explanation is that it is due to compression of nerves supplying the respiratory muscles at some point in their course.

One of the best methods of making a diagnosis is by carefully noting the patient's own movements. If we ask him to turn over while lying down, he does so carefully to prevent jarring his back. The child invariably assumes a position which will relieve the body of the weight of the head. The bodies of the vertebræ are in a spongy condition and every movement produces a mechanical disturbance. As the child walks off you can see the rigidity which is characteristic of these cases. Later, when ossification has taken place, either in a deformed or straight position, this spinal rigidity remains but it is unassociated with muscular rigidity.

This man is a case which has gone through the regular routine of just such a caries of the spine. He will be of interest to us in the differential diagnoses of Potts' disease. As he stoops to one side there is a straight line up to the site of the disease without any natural curvature. On account of the position and extent of the deformity, it is impossible for the man to lie flat on his back. I want to show you what is to be guarded against in case of caries of the dorsal vertebræ. Psoas abscess is so called because it is an abscess formed in the sheath of the psoas muscle from the pus from a vertebral caries. If the disease is high up in the cervical region, it shows itself as a post-pharyngeal abscess. Lower down the pus follows the course of the psoas muscle, and may appear at various places, the most common being in the groin. By putting the legs in a flexed position on the body so as to relax the psoas muscle, you can push your fingers back so as to feel the pulsation of the abdominal aorta. If there was a swelling here or a mass which felt like a gelatinous tumor you would have evidence that there was a psoas abscess. I can pass my fingers back very far here, and I could not do that if an abscess were present. This man a few months ago had a very large abscess showing itself above the hip joint. Fluctuation was distinct on one side, and was communicated to a mass on the other side, proving the presence of a double psoas abscess. This abscess showed itself at the hip, and the patient was operated upon. You can see this long cicatrix over the hip. It

was a case for differential diagnosis at the time referred to, as to whether it was an abscess due to hip-joint disease, or was it a psoas abscess pointing in an unusual position. You will remember the boy that Professor Forbes operated upon had caries of the vertebrae, and also a hip-joint disease; so it is possible to have both conditions present co-existing in the same patient. The diagnosis was made in this case by examining the hip-joint in the manner familiar to you. There was no rigidity of the hip-joint; we could move it freely; there was no pain. Still further evidence of the correctness of our diagnosis was had at the time of the operation, which would have to be done in either case. A probe was passed up under the gluteal muscles to the lumbar region, and from there its course could not be definitely traced, although it appeared to go in the direction of the psoas muscle, showing it was not an abscess connected with a hip-joint disease. The case was drained, and gradually the sinus healed. Whether at the present time an abscess exists, I cannot say. There is no evidence of it, and I believe it has been entirely cured. It not infrequently occurs that, following an evacuation of such an abscess, resolution takes place by the absorption of any remaining cazeation, made possible by the relief of tension.

Other joints in the differential diagnosis of caries of the spine are these:—

First, in a child there are occasionally seen sprains of the spine due to falls. These sometimes also present history of pain in the stomach and legs, irritable bladder, dyspnoea, and rigidity. In these cases it is often impossible to make an accurate diagnosis at the first visit, but by careful watching you can arrive at a conclusion.

Treat such a case as possibly caries of the spine, and allow it to go on to recovery, which it will speedily do if only a sprain. Often there are cases of rachitic spines, but here we have the other evidences of rachitis; the enlarged distal extremities of the radius and ulna, and nodes elsewhere.

But most of all in these cases there is increased mobility of the spine, instead of the rigidity of caries of the spine. In rotary lateral curvature, I could hardly conceive how there could be any difficulty in diagnosing the disease from this condition. At times in Potts' disease there is at the upper portion of the body a lateral deviation, the so-called lateral deviation of Potts' disease. This, however, is entirely different from the deviation in rotary lateral curvature. There is in Potts' disease a distinct knuckle or an-

gular curve, while in rotary lateral curvature there is a gradual bending.

In cases of hyperæsthetic, railway, or hysterical spine the spine is exquisitely sensitive. The slightest pressure causes intense pain. The method of making the diagnosis is by a study of the general condition. If there is a neurotic condition of the whole body, and the patient is a young girl at the age of puberty, you will be inclined to consider it is an hysterical spine and not caries. It is hardly worth while to enter into a study of the differential diagnosis between caries or abscess due to it, and typhlitis between hernia and psoas abscess showing itself at Poupart's ligament, or any of the other rare possibilities, because the occasions will seldom occur that will render such a diagnostic skill necessary.

At our next clinic I shall bring before you the various methods of applying mechanical restraint in the treatment of caries of the spine, and in the mean time will ask you to study the subject of the mechanical requirements as indicated to day.

SUPPURATIVE OTITIS AND CEREBRAL SYMPTOMS AFTER POSTERIOR TAMPONING FOR SEVERE EPISTAXIS.

Dr. Gellé, in speaking of the post-nasal tampon, says: The tampon both opposes the exit of blood which has already penetrated the tympanum, and facilitates the penetration of purulent secretions into an ear previously unaffected. In both cases tamponing is bad. The blood in the nostrils, pent-up, putrefies, being mixed with the microörganisms contained in the nares, and the inflammation is septic. Infectious otitis, or bilateral suppurative otitis, appears simultaneously and with the characters of gravity and rapidity of invasion common to the evolution of septic affections. If the obstacle be not removed in time, it is not the patient who will demand help—he may be in coma or delirium—and the diagnosis is made by the exit of infectious pus from one or both ears; or the patient may succumb to the propagation of the infection to the cranial cavity. [This terrible result is not rare; the author recorded a case in 1882, and has lately reported fresh instances.] Posterior tamponing is therefore, dangerous, not only to the ears, but to life itself. It is not a more or less badly made tampon, but the tamponing itself which is a bad proceeding, and the longer the tampon remains *in situ* the greater the danger.—*Journal of Laryngology, Rhinology and Etiology*, January, 1892.

COMMUNICATIONS.

LEPROSY.*

By W. H. DALY, M. D.,
PITTSBURGH.

Last March, through the courtesy of the experienced and efficient Harbor Physician, employed by the Marine Hospital Service of the United States, at Havana, Cuba, Dr. Burgess, I was enabled to examine nearly one hundred cases in the hospital for lepers, in Havana, and while I was more particularly interested in the phases and effects of the disease upon the structures, and functions, of the naso-pharynx and larynx, and other air passages, and also in the study of the fresh and recent cases, yet a general study of the disease made itself felt as one of unusual interest, since, with the great mass of busy practitioners of medicine, I had before that time only a vague idea of the clinical features of the disease, and had never in the whole course of my professional life examined carefully a case of leprosy. I would venture to say that probably 90 per cent. of the medical practitioners of the United States could neither describe the disease in many of its protean forms, or diagnosticate a recent case if they saw it for the first time.

The time has come when the National or State Legislators ought to take some adequate action to prevent the ingress of lepers to the United States, and also to forcibly isolate those already within our borders. It is therefore the duty of the profession to instruct the Legislators, and the public, upon this question. And it is a matter of congratulation to Pennsylvanians, that their State Board of Health had recently sent to the profession circulars making inquiries for the purpose of legislation, and it is to this end that I would give some views and observations briefly. But the profession could do little or nothing without the public, who are indebted to the unselfish recommendations of the medical profession for their light and life in matters of public health, by the recommendations of the latter for the stamping out of preventable diseases; hence the public ought to be informed as to the needs of the hour, and urged to act through their representatives.

An eminent dermatologist, and valued friend, Dr. L. Duncan Bulkley, of New York, had recently expressed doubts, before

the New York Academy of Medicine, as to the contagiousness of leprosy, and Dr. Daly read the published paper with some apprehensions as to the effect of the expressions of so distinguished an authority upon the profession, and there were some statements made by the doctor that ought to receive further discussion.

Dr. Bulkley stated that English observers were positive that not a case of communication of the disease had ever taken place there (in England.) This upon reflection can scarcely be taken as an argument of any weight against the contagion, as great care has always been taken to isolate leprosy in the countries comprising Great Britain, and to that persistent isolation must in a great measure be attributed, not only the stamping out of the disease, but the prevention of contagion. Some light may be thrown upon the ancient habit of isolation, by quoting an historical authority, which says:—

*“The ‘Mickle all,’ or great disease, the leprosy, which the learned call tubercular elephantiasis, prevailed in nearly every district of Europe from the tenth to the sixteenth century.

“Scotland suffered from this hideous scourge as well as other countries. It was brought as some historians write from the East by those who returned from the crusades. But this cannot be, for there were leper hospitals in England before the crusades began. The disease lingered in the northern islands of Scotland long after it had disappeared from all other parts of Britain.

“The lepers appear to have been sent to the island of Papa.”

The parish of Walls had lepers to support in Papa as late as the year 1740, as the books of the kirk-session show. In 1742 Walls held a day of public thanksgiving for the supposed final deliverance of the country from the leprosy. But there is little doubt that cases of true leprosy were to be found in Shetland up to the close of the last century.

When the leprosy seized its victim, the eye-brows and nostrils became swollen, and the countenance dusky and glossy, with a fixed look and an expression of terror. Livid pustules broke out on the face and body; the hair fell off; the voice grew hoarse and hollow. As the hideous disease advanced, ulcerating tubercles discharged a foul mat-

*Read before the Allegheny County Medical Society

*Rev. Jas. Mackenzie's History of Scotland. Published by Nelson & Sons, 1890.

ter, dark scabs formed, and face looked the like a piece of rotten cork. A sense of weight and weakness oppressed the limbs. The fingers and toes mortified and fell off joint by joint. Corruption, by a frightful anticipation, began its work without waiting for the grave.

The large number of victims were no doubt found among the lower classes of society, the bondmen, the poorer tenantry, and the humble dwellers in the towns. But neither age, nor rank, nor sex was spared. The disease must have been very common in old Scotland, for every town was obliged by law to possess a leper hospital. Every hospital was bound by Papal "bull" to be provided with its own churchyard, chapel, and ecclesiastics. Saint Anne was the patron saint of the lepers, and a chapel dedicated to her was frequently connected with the hospital. The leper hotels were not intended as places for medical treatment of the disease, but merely for the separation of the diseased from the sound, lazarettoes where the infected performed a life-long quarantine. They were for the most part founded and endowed as religious establishments, and were generally under the rule of some neighboring abbey or monastery. The inmates, doleful creatures, were expected to offer up daily prayers for the souls of the founder and his family. An order of Knighthood—the Knights of Saint Lazarus—was instituted about the time of David I. for the care of lepers. Knights of this order are said to have been common in Scotland and France. What kind or extent of power these knights were allowed to exercise over the lepers and leper houses is not known. Every person seized with leprosy within the walls of a town was removed at once to the hospital. If he had nothing of his own a collection of twenty shillings was made for his behoof. He who sheltered or concealed a leper even for a single night was heavily fined.

Some of the Scottish leper houses had large properties attached to them, and must have supported their inmates in all the comforts of which the unfortunates were capable. Others were but slenderly provided, and their miserable inhabitants were obliged to depend upon charity. The act of Parliament "anent Leper Folk," passed in the reign of James I. ordained that "no leper folk sit to beg, neither in kirk nor kirkyard, nor other place within the burghs, but at their own hospital, and at the gate of the town and other places outside of the burghs." They were allowed to enter towns for the purchase of necessities only on Mondays, Wednesdays, and Fri-

days, from ten till two o'clock, on condition that they wore a cloth on their faces, and rang a hand-bell or "clapped to give warning of their presence.

The leper hospital at Greenside, Edinburgh, was founded in the year of King James' marriage to Anne of Denmark. The money for the building was given by Jno. Robertson, merchant in Edinburgh, and others, in fulfilment of some vow. At the opening of the hospital five leper inhabitants were consigned to it. Two of the wives of these lepers voluntarily shut themselves up in the hospital with their husbands.

The rules of this hospital were probably more severe than those of other leper houses. The inmates were forbidden to go beyond the gate by day or night, work-day or holiday, on pain of death. At the gable of the hospital stood a gallows in perpetual readiness for hanging any leper who might venture forth. The rules of the house enjoined, "That the said persons and each one of them live quietly, and give no slander by banning, swearing, fighting, scolding, filthy speaking, or vicious living or any other way, under the pains to be enjoined by the (town) council. That there be appointed an ordinary reader to read the prayers every Sabbath to the said lepers, and a commodious place appointed to the said reader to that effect."

By this time, it would appear that the disease was on the wane, for in little more than sixty years after the opening of Greenside leper-house, the magistrates ordered its roof to be taken off, and the wood and slates to be used for repairing the town mills and other public buildings. The stones of the edifice itself, and of its garden wall, were applied to similar purposes.

A leper was held to be a man dead in law. He was incapable of inheriting, and lost all his civil privileges.

On the day that he was put into the hospital, the burial services were performed over him. A priest in surplice and stole went to the leper, and began the dismissal ceremony by exhorting him to suffer with patient and penitent spirit the incurable plague with which God had stricken him. He was then sprinkled with holy water, and conducted to the church, the usual funeral verses being chanted on the way. Arrived in the church, the ordinary dress of the leper was taken off. He was then wrapped in a funeral pall, and placed corpse-wise before the altar on two trestles, while the mass for the dead was sung over him. After this he was again sprinkled with holy water, and led to the hospital. A clapper and "cop," or bell and dish, a stick,

a cowl, and a leper's dress were given him. Before leaving him the priest solemnly interdicted him from appearing in public without his leper's garb—from entering inns, mills, churches and bake-houses—from touching children or giving them anything which he had touched—from washing his hands or anything that pertained to him in the common fountains or streams—from touching in the market the goods which he wished to buy with anything but his stick—from eating or drinking with any others except lepers—from walking in narrow paths—from answering those who spoke to him in the roads or streets, except in a whisper, that they may not be annoyed with his pestilent breath and infectious smell. Last of all, the priest closed the ceremony by casting a shovelful of earth on the leper's body."

By the foregoing it will be seen with what care lepers have always been isolated in Great Britain, and to what causes the presence of the disease and contagion are so rare.

Now, touching upon the case of the death of Father Damien from leprosy, while engaged among the lepers. Dr. Bulkley quotes the doubts of Dr. Rigg, of Trinidad, concerning the contagiousness, while he also expresses his own, yet he says in the course of his paper, Father Damien "may have imbibed the leprosy germ in water, food, or air," but he thought the probable source of the infection was through mosquito bites.

For all practical and hygienic purposes it is quite needless to differentiate between contagion and infection. Sufficient for either question if admitted, is segregation, and all other quarantine measures to stamp out the disease.

The *N. Y. Medical Record* says editorially in its issue of Jan. 23, 1892, "There are not many lepers in New York, but there are too many." It is needless to say that from Pittsburgh alone there are at least fifty persons who visit Havana, Cuba, during every winter, and from Pennsylvania there are probably 200. The laws concerning isolation of lepers in Havana are disgustingly and perilously lax. Many years ago there was a wealthy leper who died in Havana, and who endowed a hospital for these unfortunates. As a part of that hospital there is a spacious shrine, or church, where inmate lepers and outside citizens meet Sunday after Sunday to worship. True, the lepers are not generally allowed outside the iron gratings of the porch, but they sit inside in crowds, and traffic in the closest possible proximity, and talk at will with their friends and loungers on the spacious steps, through the iron bars. Little

children in crowds play about them on the steps, and witness the public swimming of the horses in the surf in front of the leper hospital, and, during several of my visits, a game of base ball was going on in front, and the usual crowd swarmed as lookers-on upon the hospital steps.

The public are admitted to worship in the lepers' church without restraint. At my visits the lepers gathered around me closely, and many offered freely to exchange their small and filthy paper money for silver, all willing to submit to any professional examination in their earnest desire to get relief. It is needless to say that the infected paper money finds its way into the pockets of the general public, and becomes a fertile source of contagion and infection.

I have been very much interested in the case of Joseph Miller, one of the survivors of the massacre of the crew of the filibustering ship, *Virginian*, in 1872, who was a leper inmate of the hospital. His name has been corrupted into *Amelio* by the Cubans. At the time of his rescue, he was a hale and hearty dark mulatto, but thirteen years of leprosy had turned him white; it has also made him handless, footless, sightless, noseless; it has left him without ears; it has left him without what would be recognized as a human voice; it has left him a hideous, ghastly creature, without hope in life; a mere thing, whom to look at is to make the stoutest heart shudder; whom to touch is to take the greatest possible risk of contagion that is sure to destroy. And such destruction. No other cruel thing known is so cruel, a weary journey of years, with weary limbs over which there is no power; shunned as no other being is shunned, cast out as unclean, to await the day when the horrible, hideous mass of decay will cease to live.

Whatever be the pathology of leprosy, there can be no doubt that it is a disease affecting nutrition, and which does its deadly work by absorption or ulcerative absorption of the tissues. For example, in the early cases, there will be seen on close inspection, a slight tumefaction of the skin and cellular tissue at a point on the ear, or nose, or limb. Later on there will be a gradually encroaching constriction at or near the point, and a slow absorption or amputation of the member or part. In some other early cases there is a strange alteration in the countenance and plaques of skin on the face and body, altered and bleached, or rendered livid by defective nutrition, or local inflammation.

The uninitiated might suspect syphilis, but when once seen and studied in its manifold

forms it can scarcely be mistaken. The limits of time and the subject announced, as the order of this meeting, prevent me from going farther into the subject at present.

A HISTORY OF A CASE OF DOUBLE PNEUMONIA ILLUSTRATIVE OF THE ABORTIVE TREATMENT.*

By ADOLPH KORNIG, M. D.,
PITTSBURGH, PA.

The following case of pneumonia may perhaps be deemed worthy of recital before this society. I present it for your consideration and comment. Be the initial cause of pneumonia whatever it may, I am firmly convinced that the consolidation of the lungs is due to excessive efforts on the part of nature to repair the damage that has been done to the extraordinarily vascular lung-tissue, and to guide, or more properly, to restrain, the reparative forces, is the course that would seem to be indicated in the treatment of acute lobar pneumonia. In exemplification of this line of treatment of an acute pneumonia I submit the following history: One week ago to-day at 8.30 o'clock in the morning I was called to see Mr. J. R., aged 37. The night previous, while conducting the calcium light arrangements in one of the theatres, he experienced acute shooting pains in his chest, but remained at work till the conclusion of the play. Shortly after arriving at his home, about one o'clock, he was attacked with a severe chill and suffered intense pain about the region of, and somewhat inferior to the left nipple. From that time till I saw him he suffered unremittingly, in spite of thorough application of mustard. His breathing was so difficult that the first glance was sufficient to locate the cause of his illness in his chest, and closer investigation revealed the following conditions: Pulse 108, temperature 102½°, face flushed, respiratory movements very painful and abrupt. Auscultation over the front of the chest revealed roughened respiratory murmur, but on account of the suffering of the patient the physical examination of the lungs was not very perfect. A rather profuse and extraordinarily well marked rusty expectoration, however, satisfied me as to the condition of the lungs when conjoined with the other superficial symptoms. The cough, by reason of pain, was suppressed as much as possible. The first requisite to my mind was to relieve the pain, which was accomplished by a hypodermic injection of one

fourth grain of sulphate of morphine and one one-hundred and fiftieth of a grain of sulphate of atropine. The second indication to my mind was to divert the blood stream and reduce the heart's action. With this end in view I gave him a hypodermic tablet of hydrochlorate of apomorphine of the strength of one-tenth of a grain. This I gave dry on his tongue and it would, I hoped nauseate him somewhat and initiate diaphoresis. I then wrote the following prescription:

R

Tinctura veratri viridisgtt. ℥.
Sodii salicylatis..... 3 iv
Syrupi senegae.....f 5 iij.
Aque menthae piperitæ q. s. ad f 3 iij.
M. Sig. A teaspoonful every 2 hours.

Being a man of vigorous health, weighing about 165 pounds, I considered two drops of the veratrum none too much, even conjoined with the ten grains of salicylate of sodium every two hours. The salicylate was added for the reason that some five or six years before I had attended the same patient through an attack of acute articular rheumatism, and thinking a similar influence might possibly be associated with his present illness it was added for both its anti-rheumatic and its its diaphoretic and heart sedative action.

The first dose of the prescription mentioned was given him about nine o'clock. At 3.15 P.M. he was bathed in perspiration, earning his life by the sweat of his brow, as it were; his pain was less severe, pulse 98, temperature 100°, and his cough was somewhat relieved. His expectoration was strongly tinged with a rusty color. During the time of my visit he became sick at the stomach, and vomited some grumous fluid, evidently the result of the apomorphine administered earlier in the day. At 10 P.M. his pulse was 88, temperature, 99½°, pain much relieved, face less flushed, but the perspiration was still profuse. I ordered the mustard to be reapplied.

Feb. 10. 10 A.M. Pulse 80, temperature 98½°. Countenance almost normal in expression and color. Sputum somewhat less markedly tinged, cough slight, pain produced only on deep inspiration, slept well during the previous night, diaphoresis still profuse, urine highly colored and viscid. I ordered a solution of citrate of magnesium in wineglassful doses to quench thirst and relax bowels. Thinking the severity of the attack overcome, the veratrum and salicylate were reduced to one-half the former dose.

Feb. 10. 6 P.M. Pulse 80, temperature 99½°, face a little more flushed, cough moderate, sputum rather more deeply colored. Full dose of the veratrum again resorted to. Diaphoresis less profuse.

* Read before the Allegheny County Medical Society.

Feb. 11. 9.30 A.M. Pulse 72, temperature 98½°, patient passed a comfortable night, slept considerable, cough slight, sputum still red but more faintly so, diaphoresis slight, face almost natural in color. During the past 48 hours, the patient was so moist with sweat, and was withal doing so well that it was thought best not to subject him to a physical examination of his chest. At this time, however, an examination was made, and the base of the left lung, posteriorly, was found somewhat dull on percussion, and over an area of about the size of a hand distinct crepitant rales were heard; on the right side over a smaller area the same condition was discovered, but the rales were more of a submucous variety. The fifty drops of tincture of veratrum viride and the half ounce of salicylate of sodium being exhausted, the prescription was ordered refilled, and continued in slightly reduced doses. Another bottle of magnesium was also ordered.

Feb. 11. 6 P.M. At this time the patient was seen by Dr. Pettit, who found his temperature to be 100¼°, and pulse 73. The crepitant rales on both sides were also noted by him. Diaphoresis and cough slight, pain almost absent. The pulse being reduced to about normal, he lengthened the interval between the doses of medicine to three hours.

Feb. 12. 10.30 A.M. Pulse 64, temperature 98°, patient rather pale, but feels well, expectoration still colored, cough less frequent, no pain, crepitant rales more moist, though still well marked. I discontinued the veratrum and salicylate, substituting for it the following prescription:

R Potassii iodidi..... 3i
Syrupi pruni virginiana.....
Aque Foeniculi aa..... f 3 iss.
M. Sig. A teaspoonful every three hours.

Feb. 12. 6 P.M. Pulse 72, temperature 98½°. General condition excellent. Patient begins to desire food.

Feb. 13. 11.45 A.M. Pulse 60, temperature 98°, cough rather increased, but expectoration more scanty though still tinged with yellow, crepitant rales still recognizable on both sides, though more moist in character. The medication was reduced to one-half teaspoonful every four hours, and the patient was allowed to sit up part of the day.

Feb. 14. 5.30 P.M. Pulse 64, temperature 98½°. The patient sat up all day. His appetite was good, and he was without pain. His cough was almost voluntary, but at the base of the left lung slight mucous rales could still be heard. His expectoration was colorless, and his general condition, aside from the reduced pulse rate, normal.

In the absence of consolidation and bronchial breathing some may perhaps be inclined to doubt the genuineness of the pneumonia, but when we consider the powerful influence to which the patient was subjected prior to the time when these symptoms could have been developed, their absence is easily explained. The subnormal temperature and especially the subnormal pulse, after the cessation of the inflammatory process might be considered analogous to the hypnotic, or even narcotic effect often seen after the passage of nephritic calculi where a powerful anodyne was administered, during the passage of the calculus, without, perhaps, entirely allaying the excruciating pain.—(For discussion see *Society Reports*.)

POST-PARTUM HÆMORRHAGE.*

By ROGER WILLIAMS, M D.,
PITTSBURGH, PA.

I merely desire to call your attention to a few notes on the subject of post-partum hæmorrhage, with a view of presenting a subject of interest to all engaged in the healing art, and calling to mind the conditions that eventuate in the great hæmorrhages following delivery. There is no time when action is more promptly required, and knowledge and wisdom brought into play, than, when alone one is brought into the presence of post-partum hæmorrhage. It is unnecessary to present the picture, for one experiences traces as with a stylus the tablets of memory more vividly and truly than ever artist's fingers wrought, and the whole play is necessarily so briefly enacted that we recall each incident, as we would describe a landscape seen in the lightning's flame. There is no emergency in the physician's life that gives less time for consultation and reflection, and no time more exacting to do the right thing, at the right time, and in the right way. Post-partum hæmorrhage is one of the most frequent complications of delivery. Call to mind, if you please, the many conditions you guard against in a labor about which you have doubt, and, in a vast majority, post-partum hæmorrhage is first to be feared. There is something more than intuition that places one on guard, for in the vast majority of subjects to this complication we find indisputable indices pointing to the subject in question. The patient, by reason of our wrongly-directed civilization and her whole surroundings, has engrafted a lax habit of body, inviting uterine inertia, and as a conse-

* Read before the Allegheny County Medical Society.

quence, post-partum hæmorrhage. We find illustrations of this in the upper ranks of life for they are most prone by reason of the demands of society. Education plays a part also, in inducing a premature and unhealthy development; and in support of this, I call to mind a home, almost palatial in its furnishings and surroundings, where a subject of post-partum hæmorrhage resided, and the intellectual food for thought was furnished by Boccaccio and the Queen of Navarre. Comment is unnecessary, for to the young ladies of that home, so surrounded at a period of life when quiet is most essential, the reading of such books is but the sowing of dragon's teeth, with the harvest in anticipation. Among the causes contributing may be mentioned the site and size of the placental attachment. A placenta attached to the fundus may have slight uterine attachment, and the uterine sinuses closed by nature's processes. Where the placenta is thin and covers a great surface, we may have ecstasis of the uterine vessels, and as a result, hæmorrhage. Local cedema, induced by perverted secretion, and inflammation, may prevent contraction, and as a result, we have immediate hæmorrhage. Complication to the funis, where it is interfered with and shortened, may cause a too rapid placental displacement, and therefore profuse hæmorrhage even before the child is extruded from the maternal parts.

A few years ago I delivered Mrs. G.—a multipara—and the cord, beside being tied in a knot, was entwined around arm and neck, and, during labor, the placenta was in part detached, causing a very great hæmorrhage. One peculiarity about this patient was her daily potations, which consisted of 16 ounces of tincture of opium, which she obtained clandestinely, and managed to keep her vice secret, until her maid was invited into my office, and the liquid measured not only one time, but many.

Retained portions of placenta is a frequent cause of post-partum hæmorrhage. I call to mind a case that occurred in my practice during my residence in Philadelphia. Mrs. S., 44 months in the family way, was pushed off the pavement by a swinging gate, and fell in a sitting posture to the gutter. She promptly aborted, and as the placenta could not be immediately taken away, she suffered profuse hæmorrhage, which lasted until the placenta was expelled.

There may be a proliferation of the placental vessels constituting an extra or supplementary lobe, and the retention of this even after the placenta is removed will cause pro-

fuse hæmorrhage. Plural births, with double placenta, is not an unfrequent cause of post-partum hæmorrhage, for at times the uterus seems to be irresponsible to all our efforts, and a hæmorrhage beyond what we desired is the result. I call to mind a case in illustration: Mrs. G. was delivered of twins, and the delayed second delivery was caused by an inertia induced by a beginning cancerous growth. The last delivered child was in part covered by a fleshy mass not unlike placenta, and was born dead.

Laceration of the cervix is a cause of post-partum hæmorrhage not infrequently. At times the structures of the uterine neck are hard and brittle, as well as unyielding, and, during labor, are apt to suffer to a greater or less extent. Mrs. W., a patient of mine, was delivered during my attendance at the A. M. A., at Nashville, and suffered an extensive laceration of the cervix, which was the immediate cause of an extensive hæmorrhage controlled by styptic injections and plugging.

Lacerations in the vulval canal are not unfrequently the cause of violent and prolonged hæmorrhage. Mrs. D., a primipara, was delivered by me in December last, and there was a band of tissue broad as a common lead pencil joining the labia minora, which had escaped my examination, and when labor was completed the torn end of this small impediment caused quite a hæmorrhage, which was, with difficulty, controlled by applications of Monsell salt.

Growths within the uterus, even when too small to be detected during labor, are oftentimes the cause of alarming post-partum hæmorrhage.—I saw a case of this character with Dr. McNeil, the history of which he has kindly furnished. Mrs. K., a German, aged 38, confined December 16, labor lasting 24 hours, antero-posterior diameter narrow, delivery with instruments, and nothing marked the labor out of the natural order until the 11th day, when violent hæmorrhage occurred, keeping up until the patient was almost exsanguineous. Prompt injections of hot water with vinegar, and teaspoonful-doses of ergot, relieved the hæmorrhage, and expelled a small fibroid, which was the cause of hæmorrhage. All went well until December 31, when during one of the quick atmospheric changes, the patient had a chill, rise of temperature, and died with pneumonic congestion January 5th.

As post-partum hæmorrhage is generally a preventable trouble, and where it often follows in a physician's path, rendering such a one open to censure for neglect or want of

knowledge, I claim your indulgence in this paper which may appear too long and tiresome—and yet we all have interest in a subject of such vital importance, not only to friends and family, but to ourselves, and this is my only excuse.

The character of a contraction has much to do with post-partum hæmorrhage. Admit we have a perfect contraction immediately after labor, if it is not permanent, and tonic, the relaxation may induce a fearful hæmorrhage. Post-partum hæmorrhage and permanent contraction are incompatible, I will admit, yet on examination one hour after labor and finding the uterus soft and flabby, and where coagula have not formed in the uterine sinuses, hæmorrhage will surely result.

Nature has her own way of controlling hæmorrhage by contractility of the uterus, and by plugging of the orifices of the uterine sinuses; and to assist by art when nature fails, is not an ignoble part the physician plays in attendance upon labor.

Not long ago, a physician left the bed-side of a patient with a violent post-partum hæmorrhage, with hurried direction to those who could not do what he should have done, in a fruitless quest for an instrument for transfusion. Had he gone for wings, in order that she might rise into the circumambient clouds, he should have been held less censurable, for when he returned life and hæmorrhage both had ended.

I need not speak of the secondary causes of hæmorrhage at great length, for that man who is not awake to the importance of the uterus worn out in a prolonged and exhausting effort in expelling the fœtus, or the uterus over-distended by excessive amounts of liquor amnii, or the consequences of a multiple birth, should not practice the obstetric art. Rapid emptying of the uterus is—excepting when filled with clots as a consequence of uterine hæmorrhage—baneful, jeopardizing and unskilful, and to do this to the over-distended uterus is criminal. The walls of an over-distended uterus are, to all intents and purposes, as paralyzed walls, and when the shock comes from relief of distension, it is the rule to expect retardation in contraction, and as a result, hæmorrhage of a greater or less extent.

The law is individual and not collective; and every mother is subject to the law controlling her case. True, there are principles governing, and likewise it is true we should be interpreters of the same, and should be ready at the instant to assist the tired and waning energies of the one harassed by the

prolonged and exhausting pains of labor. But how many times is it true that we have hastened labor injudiciously, and reaped as the reward some complication that should not have existed?

The over-distended uterus should be relieved on the eve of labor by careful and minute rupture of the membranes, to allow the waters to slowly drain away. I know the ground taken is dangerous, but I am supposing judicious action, and there are examples of such action that have been praiseworthy to the operator, and to the one operated upon, helpful. I beg leave to cite an illustration: Mrs. P., enormously distended, a sufferer from ever-present pain, sleepless, and in constant dread lest she should never arrive at the day of accouchement, was advised to have the sac of waters carefully ruptured; for two days there was a constant flow, and at the end of that time she went into labor, and was delivered of twins, one weighing 9½ pounds and the other 8½. The uterus was firmly held for an hour to guard against hæmorrhage impending, and she made a rapid convalescence. An over-distended uterus is always a dangerous uterus, and should never be left until every indication is given that no emergency arises, especially as to hæmorrhage; for the greater number of deaths resulting from hæmorrhage during the last fifteen years in the Liberty Valley have been from this cause.

I am indebted to a brother practitioner for the following: Mrs. W., aged 23, delivered in November, 1891, labor normal, and of six hours duration; uterus greatly distended by amniotic fluid; secundines removed without trouble. Four hours after labor, profuse hæmorrhage set in, leaving the uterus spongy and enlarged. Contractility of the uterus weak, and as the patient could not take ergot, the hæmorrhage was kept in abeyance by injections of hot water for three hours, when it returned, with alarming conditions. Clots were speedily removed and warm water injected, controlling the hæmorrhage, but the patient was exsanguious, weak, and exhausted. Digitalis and stimulants were freely used, but the patient died on the tenth day from complication referable to the lungs. There was not at any time septic trouble.

Irregular contraction is a cause of post-partum hæmorrhages not uncommon. Part of the muscular fibres are relaxed, while part are in a state of contraction; the former often over the placental site, and is the cause of considerable hæmorrhage. By palpation this condition is easily discerned.

Hour-glass contraction is also a cause of post-partum hæmorrhage; rare it is true, yet nevertheless occurring. This condition follows often the obstetrician, who, by efforts of traction, excites uterine contraction at the seat of irritation—often the placental attachment, and many times the internal os, and, as a cause we have a diaphragm temporarily placed, with placenta in part or wholly included within the uterus, and hæmorrhage of a greater or less extent resulting. This condition rarely, if ever, follows after efforts of placental expression, and as this form of delivery of the after-birth grows into favor, hour-glass contraction grows less.

Encystment of the placenta is one of the rare complications of labor, and when it occurs, the placental site remains more or less paralyzed, whilst the remaining muscular fibres are in contractility. This form of trouble in the delivery of the after-birth is apt to be mistaken for adherent placenta, and oftentimes a part of it is left intra-uterine, as a result of wrongly directed effort, and hæmorrhage results, complicated at times by sepsis.

The placenta and membranes, and also the decidua, may be the seat of calcareous or fibroid degeneration, or the decidua may be abnormally thick. When an accident of this character to a part of the placenta or its membranes occurs, we have a cause of irritation not unlike a foreign body placed against the maternal tissues, and as a consequence, loosening of attachment in part, or an inflammation that causes adherent placenta. I think the many cases of adherent after-birth can be traced to one of the conditions mentioned; but, be this as it may, the hæmorrhage in this complication is not to be lightly considered, for the placental site is in a state of irritation, and its muscular fibres will respond freely.

Concealed hæmorrhage, following delivery, is a subject of interest to all. That fatal hæmorrhage of this character exists, many here will attest, and the obstetrician should ever be on guard. The flabby uterus rendered insensable, and worn out by long continued labor, may, by bleeding within itself, rob its subject of life. The external evidences of hæmorrhages may be normal, but where there is evidence of hæmorrhage the practiced eye detects at once. The conditions leading up to this are referable to clots, and at times membranes acting as a valve within the internal os. Illustrative of this, I am furnished the history of Mrs. —, delivered at Homewood, in the summer of '91, who passed through a normal labor until the ninth

day, when her physician was sent for, and found her pale, weak and bloodless. A syringe and hot water removed two quarts of clots. Phlebitis complicated the case, but the patient recovered.

Patients constitutionally predisposed to flooding are perhaps the most interesting of the class mentioned, and well merit the appellation of "bleeders." They follow the inclination of predisposition, in spite of every effort the physician puts forth, to a certain extent, and at times only mechanical pressure will relieve.

There are few sights more dreadful to look upon than the worst cases of post-partum hæmorrhage. A reign of terror ushers it into view, and that one who is at his post, equal to the occasion and to the emergencies that arise, has within him the elements of a hero. The pulse is a mere thread, or perhaps is imperceptible; syncope manifests itself, and with it is born a hope of thrombosis in the venous sinuses; and yet there may be fatal syncope. Intense weariness and faintness comes on, and the patient, wildly tossing her arms, is with difficulty restrained. Respiration becomes gasping and sighing, suffocation seems impending, and the patient calls for more air. The skin is deadly cold, the face pale, and covered with profuse perspiration. If the hæmorrhage is not controlled, loss of vision, jactitation, convulsions, and death speedily follow.

The treatment in post-partum hæmorrhage, principally, should consist in using preventive measures. If the uterus is firmly held in contraction until the secundines are extruded, and the fundus held in the grasp of the hand until the first half hour is past; if only, when assured that permanent contraction has manifested itself, the binder is firmly applied, and, if a full dose of ergot is immediately given, cases of post-partum hæmorrhage would be much less frequent. If the history of the patient is one of post-partum hæmorrhage, then a greater care should be taken. It will be well to administer subcutaneously, a half hour before the supposed termination of labor, a full dose of ergotine. If then the os is dilatable, and one has prepared for the emergencies that *might* arise, rupture the membranes, and take advantage of every means to insure regular and, if possible, permanent contraction. If the pulse does not fall slightly below, or comes to the normal in 20 minutes after labor is completed, this in itself is indicative of impending hæmorrhage, and then prompt treatment of tendencies, especially referable to relaxation, demands the intra-uterine administration of

remedies to control hæmorrhage. Ice, with uneven edges removed by immersion in hot water, carried to the fundus, and held until contraction is induced, or ice water—if the surrounding parts are protected—by injection, or water of the temperature of 120 to 130 degrees, by the same means, and persisted in until contractions are invoked. Absolutely hot water favors coagulation in the uterine sinuses, and in those nervously disposed, is a form of treatment suited. It is supposed that subcutaneous injection of ergotine has been used, or that ergot in the form of *fd. ex.* has been given in sufficient quantities. Antiseptic wool carried to the bleeding surfaces is to be used, and in the selection of remedies, there is the choice of dilute acetic acid, chloroform, or the mineral astringents. If a powder-blower is at hand, and the parts admit, the use of pulverized nutgalls will serve a goodly purpose, and is a safe means of arresting hæmorrhage. The application of *tr. iodine* is also efficacious, and can be readily applied on wool. Strength of the patient must be maintained, compensation for the loss of blood looked after, and to this end, injections of drachm doses of ether play a part, with the inhalation of nitrite of amyl, or the injection of stimulants. Alcoholic-saline intravenous injection gives back tension, and supplies, in part, the fearful waste. These failing, the abdominal aorta can be compressed, or the uterus held firmly by the hand sufficiently long to aid in the formation of coagula.—(*For discussion, see Society Reports.*)

INOCULATION OF PHYSICIANS WITH SYPHILIS.

Dr. James D. White, of Boston, says that he has notes of fifteen cases of syphilis in physicians who were inoculated upon their hands while engaged in professional duties. Three of these died from the disease. All of them suffered greatly in mind, and were more or physically disabled or disfigured for a time. He suggests (*Boston Medical Journal*): First, always wash one's hands immediately after an interview with a patient who has, or is suspected to have, syphilis, without regard to the condition of the parts touched, or even if not handled at all. This should be made an invariable custom. Second, the physician should regard every persistent sore upon himself, of whatever seat and however innocent apparently, as a possible lesion of tuberculosis or syphilis, and seek competent advice without delay. Such advice is never found at home.

SOCIETY REPORTS.

ALLEGHENY COUNTY MEDICAL SOCIETY.

Scientific Meeting, February 16th 1892.

J. C. LANGE, M. D., PRESIDENT, IN THE CHAIR.

Dr. Koenig read a paper entitled "A History of a Case of Double Pneumonia Illustrative of the Abortive Treatment." (See p. 651.)

DISCUSSION.

DR. RIGG: I believe this is the proper treatment. It is the treatment that should be followed in pneumonia with very few exceptions. The selection, however of the particular cardiac sedative is the choice of the practitioner. I prefer aconite, but I will leave that entirely with the individual physician. In the early stage of pneumonia stimulants have been recently recommended and recently condemned; I think they are injurious; they are contrary to the effect you want to produce. I have been following that treatment for the last thirteen years, and I have no reason to regret it, no reason to believe that any other treatment I have seen, and have at times taken part in, is any better.

DR. DUFF: I was very much impressed with this case which is certainly well worthy of remembrance. My observation teaches me to believe that salicylate of sodium is one of the best remedies of this kind. I wish to call attention to the fact that salicylate of sodium is one of the most efficacious remedies in my hands, and in the hands of several practitioners with whom I have spoken on this subject. There is a condition in pneumonia analogous to that we have in rheumatism, and the operation of the medicine is to a certain extent in the same line.

DR. THOMAS: I wish to corroborate what Dr. Duff has stated, that salicylate of sodium is possibly one of the best remedies in pneumonia. In the *Pittsburgh Medical Journal* some years ago I gave the statistics of the continuance or the length of the disease, and the average limit of the disease as treated by salicylate of sodium. I look upon the disease as analogous in its character to rheumatism, and that both exist under a similar climatic condition, and that both require pretty much the one treatment. I do not remember what year my report was made, but if any of you wish to refer to it, you can get it in the journal published by Dr. Gallaher some years ago.

April 23, 1892.

Society Reports.

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DR. DALY: There can be no doubt that, viewed as a great controller of the heart's action in inflammatory diseases, *veratrum viride* is a very useful remedy. I have used it more or less for twenty years, but it has always occurred to me that a more important point, or quite as important a point, is to know when to abate its administration. It is so potent a remedy that unless good judgment is observed in abatement of the dose, serious harm may be done with it. I have for many years been in the habit of instructing the nurse to count the pulse, with the instructions that when the pulse fell to 95, with some moisture about the hands, to increase the interval of the dose and diminish its quantity to $\frac{1}{2}$ or $\frac{1}{3}$ of whatever had been given, and with instructions that if the febrile action increased to increase the dose again.

With reference to the value of salicylate of sodium in pneumonia, I think many can testify to its value, but I presume it is of value because of the common origin, frequently, of pneumonia and acute rheumatism. I think every man who has been an observer in the practice of medicine for fifteen or twenty years, or even less, will come to the conclusion that many acute pulmonary affections, such as bronchitis and pneumonia, have their origin within the system, not without the system at all, from the retention of broken down products. What we may regard as a rheumatic condition may in one case produce rheumatism and in another case pneumonia, in another case rheumatic bronchitis, or even a rheumatic pleurisy; that I have demonstrated to my own satisfaction more than once, and therefore it is reasonable that salicylate of sodium gives such results as it does. It will also reduce temperature and the heart's action, and for prompt and efficient work it is very difficult to find a remedy equal to it; but one must know when to stop the remedy.

DR. BORLAND: I have used tincture of aconite with about the same results as Dr. König has had with *veratrum viride*. Salicylate of sodium, in my experience has been satisfactory in many cases, but it is hard on the stomach, and for this reason I have not been able to give full doses. What is called salicylate of sodium, that preparation that is made use of in filling prescriptions, is a preparation I understand made from coal tar products, or, in other words, there is no true salicylate of sodium about it. Salicylic acid, which is made use of, is a synthetical product. I am in the habit of ordering the true salicylic acid and combining it with ordinary carbonate of sodium. I find that

this combination is more easily borne, and has better effects.

DR. DAVIS: I would like to state that I have never in private practice been able to give salicylate of sodium longer than twenty-four or thirty-six hours. In hospital patients, where we can control them, we can prosecute the administration longer, but I do not know a patient who can resist and will not resist after forty-eight hours. It is so repulsive that the taste is a factor in starting a rebellion in the stomach and palate of the patient.

DR. DUFF: Mr. Davis's remarks are certainly a revelation to me. As a rule, I have had patients taking large doses, very large doses, of it for a week at a time without any bad results.

DR. BATTEN: I have been in the habit of prescribing salicylate of sodium in rheumatism, and I have often continued it for two weeks, and I have never found any bad results from the taking of it, or any effect on the stomach, nor found that my patient objected to taking it. I have thought that salicylate of sodium was pleasant to take.

DR. KÖNIG, in closing the discussion, said: I desire to recall the attention of the society to a statement that I made, which has, judging from the discussion, apparently been overlooked; it is namely: That the antiphlogistic action was initiated by apomorphine, one of the most powerful depressants and emetics in the entire pharmacopœia, and it probably had much to do with the abrupt termination of the pneumonia. I want also to express my appreciation of the danger that is associated with the administration of large doses of heart sedatives; for that reason I made three visits to this patient in one day. No doubt what Dr. Rigg and Dr. Borland stated, that many other remedies will accomplish the same result, is true. There are many roads that lead to Rome, though some may be more direct or otherwise preferable than others. Aconite or tartar emetic will accomplish the same result; but if I were to give aconite in sufficient amount to accomplish what the *veratrum viride* and salicylate of sodium did, I would want to sit at the bedside of the patient. I have no doubt it is an excellent remedy, more rapid in its action, and perhaps more certain, but unless closely watched, we unnecessarily risk the life of the patient. In *veratrum viride* there are two or more alkaloids, one of which is powerfully heart sedative, while another is emetic, but less marked so than the heart sedative one; before, however, the sedation can go to a fatal limit the emetic action is established and the stomach emptied of its remaining contents.

Dr. Roger Williams then read a paper on "Post-partum Hæmorrhages." (See page 652).

DISCUSSION.

DR. DAVIS: The doctor has not only opened the discussion, but he has so very thoroughly covered the ground that it leaves little room for any one to add anything, but rather repeat in the way of emphasis some of the statements he has made. There is one cause of post-partum hæmorrhage that I did not notice being mentioned, that is the use of anæsthetics in labor. I believe it is the experience of all that the use of chloroform or any other anæsthetic in labor, is very liable to leave the patient in such a condition that the normal stimulus of the last throes of labor are removed and a lassitude follows the removal of pain, so it is a question as to how to resort to anæsthetics. It is necessary to be very careful in following all the details the reader has mentioned, in regard to the pressing down of the uterus and holding it pressed and keeping it in observation all the time until the patient has rallied, and I think where this precaution is not observed, there are many cases of hæmorrhage as the result; not always fatal hæmorrhage, but a hæmorrhage that would be avoided if these precautions were observed. The doctor has clearly outlined the magnitude and gravity of the diseased condition, because in a great majority of cases it is a diseased condition, a pathological condition, not a physiological one, and I know of nothing we are called on to attend that so alarms physicians and attendants as this. I recall the words of old Dr. Meigs when he so wonderfully demonstrated the condition. He would show us in so vivid a manner the accident; he would then mention the remedies to use, and he said after you have used these you will throw up your hands and wish to the Lord old Meigs was there. I tell you, it has come to us all over and over again, when these patients seem, in spite of all remedies, to resist every endeavor to bring that uterus down, we do wish for help from any source or from every source. I would like to emphasize the hot water. It is one of the more recent ones, and it is one I have had experience with myself. In hæmorrhage, where I have felt safe, I have introduced ice rapidly, large quantities and satisfactorily, but not so satisfactorily it seems to me, not so promptly and fully as in the use of hot water. Most houses now, at least all well-to-do houses, have syringes of some kind, and if this water has been thoroughly boiled and cooled sufficient for the purpose, it is disinfected by that means,

and I think can be used safely in large quantities, and its action in causing contraction is very prompt, and even where that is not so prompt, it does constrict the vessels and at least the hæmorrhage is controlled.

DR. THOMAS: There is one place in the paper where the gentleman spoke of rupturing the membranes. Teachers of obstetrics advise not to rupture the membranes, but I hold and have always advocated such practice. I think after labor begins the sooner the membrane is ruptured the better, and in a large practice of obstetrics as a rule I have followed it. To produce artificial labor the membranes are ruptured, so I hold that after the full period of uterine gestation has arrived, the membranes are in the road. There is one other point the reader spoke of, and that is to give large doses of ergot. Now I think that is a mistake. If you give large doses you produce an exaggerated contraction, and if you have that, you necessarily have following an exaggerated relaxation, so that in giving it to control hæmorrhage, it is better to give small doses and give them oftener. If there is anything that raises large beads of sweat on a man's forehead, it is when he attends to a case of confinement, and after the delivery or before the delivery, he hears the blood rushing out. There is nothing in the entire practice of medicine that impresses a man more than that condition. Now you talk about ice, you may talk about syringes and hot water. If a man finds himself with such a case how in the name of common sense is he going to run and get ice, inquire of the parties if a syringe is at hand, and if not rush to the drug store and get one? The way the hæmorrhage flows out, if you wait your patient will be dead before you have these things prepared. Sometimes you can almost tell that a woman is going to have a hæmorrhage; I have done that more than once. Where I suspect there is danger of hæmorrhage, I take precautions beforehand to have a pint or two of vinegar. I do not tell this in the hearing of the patient, but I tell them I want a pint of vinegar and a clean kerchief or a small towel, and if I have hæmorrhage of that kind, I roll the towel around my hand, saturate it with vinegar, pass it up the uterus, and I have never failed to constrict the vessels and check the hæmorrhage.

DR. BLUME: The subject of post-partum hæmorrhage is certainly of importance to every physician. The doctor has fully given the different causes, as well as the treatment of this complication. I wish in the first place to call your attention to one point—

to the question—Is it possible to prevent post-partum hæmorrhage? My answer is, the proper management of the third stage of labor will render these accidents extremely rare. Unfortunately there is still a diversity of opinion as to what is the proper treatment in the third stage of labor. Some writers say the uterus must be grasped and firmly compressed as soon as the head emerges; some insist upon compressing the fundus as soon as the child is delivered. Some say it must be done about fifteen minutes after the delivery of the child; still others leave the separation of the placenta and its expulsion through the contraction-ring to the powers of nature. If you do this you do not need to be afraid of post-partum hæmorrhage; there will be very little blood lost under these circumstances in a very great majority of cases. It would lead me too far to demonstrate to you that this last view is the correct one. The observer will find that there is very little loss of blood, in some cases almost nothing; he will also find that the uterus remains more contracted if this plan has been followed.

As Dr. Thomas said, ergot, especially large doses of ergot, has the effect of over-stimulating. About three or four years ago I published a paper on this subject, and especially about the third stage of labor. I have not had one case of post-partum hæmorrhage within the last eight or nine years since I have been following this plan of treatment of the third stage of labor, I say of post-partum hæmorrhage, and I exclude all those hæmorrhages which arise from lacerations. As regards the treatment, I again agree with Dr. Thomas, that it is often impossible to use cold or hot water. You have not the time to do it. If it is some mild form of hæmorrhage compression of the fundus will arrest it; if it is a serious hæmorrhage, you lose too much time before you have it ready. If I had it to do, I would simply introduce my hand into the uterus, take the other hand and grasp the fundus and make a compression of the uterus. I think very few cases will resist this treatment. The best result has been obtained in various cases by tamponing the uterus and vagina with iodoform gauze.

DR. BATTEN: I venture to say that if any of us had a case of post-partum hæmorrhage to-night, we would not likely do anything that has been recommended, because we have not the appliances nor have we the time to wait. I believe that the husbanding of the second stage of labor to prevent post-partum hæmorrhage, is as important, if not more important than the third stage of la-

bor. In my career I have had but two cases of post-partum hæmorrhage. One was not a very bad case. The other was a very bad case, and the woman finally died. I was not there at the time the child was born, nor for an hour afterwards, and when I arrived at the patient's side I found her *in articulo mortis*. I had attended her in three previous births. In another case of post-partum hæmorrhage, a case I saw with another physician, we governed the bleeding by each alternately holding or pressing the womb well down in the pelvis and giving ergot. The moment either of us would take the hand off the uterus it would become flabby. I am a great advocate of the rapid delivery of the after-birth when the second stage of labor is complete. It is very important that the clots and all the membranes that might remain in the uterus be removed, and that the womb should be well contracted before putting on the bandage. I would object to giving ergot in any shape, either by injection or by the mouth before the child is born, because I think it would lead to difficulties afterwards that might otherwise be avoided.

DR. KENIG: I want to say a word in favor of that much-abused remedy, ergot. According to my understanding the difference between ergot and the natural contraction is that the contraction by ergot is continuous. If you get the uterus contracted by large doses of ergot it does not relax. I myself have seen very few cases of serious post-partum hæmorrhage. I am sure, however, that if I had ergot at hand, I would give at least half an ounce of the fluid extract as soon as the manual manipulations should have succeeded in bringing about contractions, and time could be spared to administer the medicine.

DR. MACFARLANE: There is just one thing I wish to speak of—the matter of ergot. It was thought it should be given in all cases, and I think there are those who rely upon ergot to the exclusion of other things. I agree with Dr. Blume that the proper way of treating a post-partum hæmorrhage is to induce contraction of the uterus by the introduction of one hand into the uterus and placing the other one upon the fundus. I think the presence of the hand in the womb is sufficient. There is one thing I wish to commend to those who have not done much such work, that the doctor has made mention of in this paper, that is, the significance of a quick, rapid pulse. Though quick and rapid you may not have a post-partum hæmorrhage in the true sense of the word, but you are going to have a uterus that will relax again

and fill with clots and give you trouble; and there are those who give ergot under these circumstances, and especially beginners will give the patient a dose of ergot. The proper thing to do is to empty the uterus with a few fingers, and usually the contraction will be sufficient to check such hæmorrhages without any ergot at all. Mention has been made of the binder, and I know people who put it on with as much regularity as they say their prayers at night. I think with the average woman, by the time you raise her up and have that binder put underneath her, you will do more harm than good. Even in hæmorrhages of any kind, it is not the custom with me to put on the binder. Once you have the uterus contracted, and you remain by your patient a length of time to assure you it is permanent, I do not think there is any occasion for the binder. Dr. Thomas has stated here that the proper thing to do under any and all circumstances, if full term has arrived, is to rupture the membrane. I wish to take exceptions to it. A labor can be carried through to such time as it will rupture of its own accord, with much more comfort, and it is certainly easier on the mother's part to have a soft bag than a resisting bag.

DR. MURDOCH: No man should introduce his hand into the uterus, unless for some such grave accident as this post-partum hæmorrhage, and only then when the post-partum hæmorrhage threatens to be fatal. I mention this because the matter was vividly brought to my mind last night by a young practitioner, who told me that two weeks ago he attended a case in which there was post-partum hæmorrhage, and for the purpose of arresting it he called for a syringe, and he injected it with hot water and arrested the hæmorrhage; but in a few days the woman was taken with fever and died within a short time, of septic poison. Now, if this goes abroad that in cases of post-partum hæmorrhage, the practitioner is at liberty to take a cloth or towel and wrap it in his hand and saturate with vinegar and push it into the uterine cavity, practitioners who have not had as much experience as Dr. Thomas has, get to think that is the proper course to pursue. Some of them may think that the loss of a few ounces of blood after delivery justifies them in the use of some such means to arrest the hæmorrhage, and they may for a trivial trouble introduce that into the system of woman which may cause her death. It is a serious matter to introduce the hand into the uterus, and in injecting hot water in a hurry, nine times out of ten you will not get water that is boiled, but that which is filled with septic matter;

and you may for the purpose of arresting a hæmorrhage that will not prove fatal inject it in the system and probably cause the woman's death. I believe that, generally speaking, the hæmorrhage can be arrested without such means, but there are occasions where it is probably justifiable, and I have myself resorted to it. I am a believer in hastening the third state of labor; I believe in doing it according to the method of Crede. I also agree with Dr. Macfarlane that the binder is an obsolete means of producing pressure, and is not worthless, but worse than worthless—it is a nuisance.

DR. DUFF: I cannot help allowing the words of Prof. Hersh to ring in my ears. "Where a second case of post-partum hæmorrhage follows a man, he is certainly ignorant or guilty of negligence." When I say this I do not for a moment entertain the belief that cases of post-partum hæmorrhage are not a necessity in almost, if not every man's practice; not inevitable, but they should not be frequent, if proper precautions are taken. There have been remarks here to-night suggesting the impossibility of having proper instruments at hand. One certainly has a right to speak disparagingly of a physician who goes on his round day after day and night after night, waiting on the mothers of our land, without having himself provided with those instruments and remedies which may become necessary in the course of his practice, without time to run around and hunt them up; and hence while a physician does make a very great display when he has a table in the room and places his instruments upon it, which I would condemn to a certain extent, he is certainly practicing obstetrics according to the line of his duty, in being prepared for emergencies. Coming to the subject of post-partum hæmorrhage directly, the doctor did not illustrate the difference between the different characters of post-partum hæmorrhage, and in the discussion almost all have spoken of post-partum hæmorrhage which comes from the detachment of the placenta. Hæmorrhages from laceration are of different character, and it is very important that we recognize this difference. I know of a woman who died not five miles away from here, because her physicians did not recognize the fact that the hæmorrhage they were endeavoring to control did not come from the uterus, but from laceration. They kept the uterus pressed down, kept it contracted, and applied lemon juice and hot water, but the hæmorrhage went on, and the woman died; whereas, if they had recognized the true condition and taken hold of that

uterus and sewed the rent, they could have saved her in all probability. Now, with regard to the treatment, the doctor did not distinguish between contraction and retraction, as an element in post-partum hæmorrhage. We have contraction and retraction, and if you have plenty of contraction and not any retraction, you will still have hæmorrhage from the uterus. With regard to the use of ergot, it will produce contraction, but it does not produce retraction, either of the muscles or the blood vessels, and when the contraction passes off, not having retraction, you are a little more likely to have hæmorrhage than if you had not given ergot.

There are some methods of treatment of post-partum hæmorrhage that have not been mentioned. The condition of the patient must be taken into consideration, as has been stated by some one, outside of the condition of the uterus. If hæmorrhage came on, I would take the forceps and pull the uterus down, and with a pair of forceps I would take gauze and push it up into the uterus, and the hæmorrhage in ninety-nine cases out of one hundred would cease. I would never hasten to turn the uterus inside out as do Koch and others. Another thing to be done is to make pressure. I believe Beringer and Foster advocate pressure upon the abdominal aorta, one through the uterus, and the other the abdominal walls, and forcing all the blood that remains in the woman's body up to the brain as much as possible. The subject is a very interesting one to me, and I feel of all the operations we undertake there is none in which we must be braver, bolder, and more determined, and more active.

DR. WILLIAMS: I do not intend to take much of your time. In regard to the criticism of Dr. Thomas, I did not state any dose of ergot; all I suggested was the injection of ergotine, when we anticipated in a few minutes to half an hour labor would be over to get the effect of ergot. In regard to the use of ergot, I am a firm believer in its value, that it will produce contraction. Some criticisms have been made on the binder. I mentioned that after you were assured that you had permanent and constant contraction, the application of the binder would more firmly hold the uterus to its place, not to immediately apply the bandage.

DR. R. STANBURY SUTTON.

Dr. Sutton has been elected Gynecologist to the Allegheny General Hospital, Allegheny, Pa., and given a separate building for his work, which he has already begun.

SELECTED FORMULÆ.

HYDROPSY OF CARDIAC ORIGIN.

R Digitalis leaves.....5 ss.
 Boiling water.....3 viij.
 Make an infusion and add citrate of caffeine.....5 ss.
 Tinct. strophanthus.....5 i.
 Acetate of potash.....5 v.
 Extract of licorice.....5 l.

S. The whole to be taken in spoonful doses within 48 hours.

—Union Médicale.

DEPILATORY.

R Carbonate of soda.....5 j.
 Quicklime (fresh).....5 ss.
 Powdered charcoal.....grs. viij.
 Glycerin—concentrated.....5 j.
 Lard—dehydrated.....5 viij.
 M. S. A. After this has been applied for ten days the skin assumes a rose tint, and the hair may be drawn out without pain. It is imperative that the quicklime be fresh, and the glycerin and lard contain as little water as possible.

QUININE FOR INFANTS.

Lutz has proposed the following formula, which masks the bitter taste:

R Sulphate of quinine.....gr. viij.
 Dilute sulphuric acid, 1 per cent.....ij viij.
 Essence of peppermint.....ij v.
 Saturated solution saccharine.....5 lii.
 Water.....5 lii.

—Gazette des Hôpitaux.

CAMPHOR IN INFLUENZA.

Dr. Deveruk (*La Semaine médicale*, No. 45, 1891) recommends camphor as one of the best remedies in influenza and similar states. He used the following formula in over 150 cases:

R Alcohol camphorat.....grammes 8.
 Syrup chloroform....." 10.
 Nucilag. gumm. tragacanth....." 60.
 Aqua....." 150.

A spoonful every two hours.

CHRONIC PRURIGINOUS ECZEMA.

Unna suggests the following ointment in cases of chronic eczema, where there is considerable pruritus and deep infiltration of the skin:

R Cælii chloridi liquidi.....grammes 40.
 Olei cadini....." 10.
 Lanolini....." 20.
 Unguenti sineti oxidi....." 30.

—*L'Union Médicale*, Dec. 22, 1891, p. 899.

DISINFECTANT MOUTH-WASH.

The following combination has been found both a pleasant and efficient disinfectant:

R Thymol.....gr. iiij.
 Benzoic acid....." xl.
 Tincture of eucalyptus.....5 iiij.
 Essence of peppermint....." x.
 Alcohol.....5 iiij.

M. Sig. Four enough in a glass of water to render it turbid, and use as a mouth-wash.

—Thomas.

CHLOROSIS.

Dr. Pick (*Wiener klin. Wochenschr.*), basing his procedures upon the supposition that chlorosis is due to an auto-intoxication by toxins absorbed from the stomach, washes out the stomach, in the morning, and administers immediately afterwards, some preparation of iron. With this treatment he has been able to get results in three or four weeks, where, under the ordinary method of administering iron, no results would be obtained for months. If this fails he prescribes:

R Cream.....cgms. 5.
Sugar of milk....." 30.
Sufficient for one capsule. Take one capsule immediately after each meal.

EXPECTORANT.

R Tr. opil camph.....3 i.
Srt. ammon. arom.....3 i.
Ext. ipecac fl.....3 ss.
Syr. prim. virg.....3 i.
Aque, ad.....3 viii.
M. Sig. A teaspoonful three or four times daily for a child.

CHILBLAINS.

Morrow prescribes:

R Carbolic acid.....
Tannic acid.....3*ss*. 1.
Tincture of iodine.....2.
Vaseline (albolene).....30.
M. Sig. Apply to the affected parts three or four times a day.

HYDROCHLORIC ACID IN DIPHThERIA.

Roux and Yersin have shown that the virulence of diphtheritic toxins may be greatly diminished by the local application of small quantities of acid. Krazenski employs hydrochloric acid in the following formula:

R Perchloride of iron.....3 i.
Medicinal hydrochloric acid.....*℥* xv.
Distilled water.....3 vi.
S.—A teaspoonful every 15 minutes for four doses, then every 30 minutes for 3 or 4 hours, finally every hour.

R Perchloride of iron.....3 ii.
Hydrochloric acid.....*℥* xv.
Distilled water.....3 i.
S. Apply locally every two hours.

—Times and Register.

FOR IRRITABLE HEART.

Dr. J. Hobart Egbert states that a young girl whose irritable heart did not improve under digitalis and belladonna (*Notes on New Remedies*) improved rapidly under the following:

R Chloralamid.....3 iv.
Tinct. belladonna.....3 ij.
Elixir simple.....q. s. ad 3 iv.
M. Sig. Teaspoonful three times daily, between meals and at bedtime.

And

R Ferri et quinine citrat.....3 iv.
Tinct. nucis vomic.....3 ij.
Syr. simple.....q. s. ad 3 vj.
M. Sig. Teaspoonful after meals.

SEA FOAM.

(DRY SHAMPOO.)

R Alcohol.....3 vij.
Water.....3 x.
Ammonia water.....3 j.
Cologne.....3 j.
Tinct. green soap.....3 iv.
M. Use as a shampoo and wash off with clear water

SCROFULOUS OPHTHALMIA.

The following recipe was much used by the late Dr. C. Fronefield in this troublesome disease:

R Ext. belladonna.....gr. v.
Chloroform.....3 ss.
Aque.....3 viij.
M. Sig. Wash two or three times daily.

Also:

R Quin. sulph.....3 jss.
Liq. potass. arsen.....gtt. x.
Ext. hyoscyami.....gr. ij.
M. et fet. Fil. 60. Sig. One ter die.

ANÆMIA.

For a young girl fifteen years of age, Prof. DaCosta prescribed:

R Sodii arsenit.....gr. $\frac{1}{4}$.
Ferri sulphat.....*℥* j.
Potassii carbonat.....gr. ij.
M. One pill three times a day, the dose to be gradually increased.

Also a diet of fresh animal food, with green vegetables by forced feeding (four or five meals in the twenty-four hours), or if quantity is an objection, the freshly extracted juices of meat may be given. Red wines might also be given with advantage, and the patient should lead an out-door life.

ASTHMA.

Dr. Huchard, of Paris (*Le Bulletin médical*, No. 9, 1892), praises the following formula in the treatment of asthma:

R Iodide of potash,
Tinct. of lobelia,
Tinct. of polygala.....3*ss* grammes 10.
Extract of opium.....dgms. 10.
Water.....grammes 900.

A teaspoonful morning and evening in a quarter of a glass of water.

The addition of the opium increases the tolerance of the stomach for the alkaline iodide; the iodide of sodium may be used fully as well.

VULVAR ECZEMA.

Lusch advises:

R Bicarbonate of sodium.....grammes 8.
Bicarbonate of potassium....." 4.
Neutral glycerin....." 6.
Tincture of opium....." 8.
Water....." 3*ss*.

Ft. sol. For use as a lotion morning and evening. After using the lotion apply a powder composed of starch 10 parts and powdered camphor 2 parts.

—*Le Progrès Médical*.

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LEADING ARTICLE.

THE THERAPEUTIC USES OF IODOL.

Iodol is not one of the many new drugs that are taken hold of and used by the practising physician and then laid aside soon afterwards, not only as valueless but sometimes as dangerous remedies. Since its introduction in 1885 by Vulpus and Mazzoni, iodol has invited considerable attention, and to-day it may be said that the drug has, in conformity with its claims as a therapeutic agent, an undoubted value and obtained a permanent place in practical medicine. Indeed, few of the newer drugs have had such an extensive trial with such excellent general results. It has been employed both internally and externally, and has been found to be of special value as an antiseptic and alterative. As a whole, there is sufficient evidence to prove that it possesses superior advantages over corrosive sublimate, and especially over iodoform. A study of the literature regarding the therapeutic uses of the drug in question will sustain these assertions.

Iodol was first brought into notice by Mazzoni who largely used it in syphilitic disorders, adenitis, periadenitis and chancres, which were greatly benefited by it. Locally applied, it was found serviceable in the treatment of large suppurating ulcers, in which, in the course of 24 hours, it not only produced a lessening of the discharge but also a favorable change in the morbid processes, followed soon afterwards by a healthy granulation and cicatrization. As an antiseptic its good effects have been observed in erysipelas and diphtheria. Later studies have led Mazzoni to consider iodol an excellent remedy in the treatment of hydrocele, and of synovitis of the wrist-joint, particularly in the latter disease after the acute stage has passed. In such instances, pain and the disagreeable sense of heat have disappeared within 24 to 48 hours. Two cases of hydrocele were radically cured in 2 and 4 weeks respectively by the exclusive use of injections of a solution of the remedy.

Wolf has noticed that under iodol venereal ulcers heal more slowly, than under iodoform, but that, on the contrary, they do so more

rapidly when the lesions have been previously treated with salicylic acid.

From a series of clinical observations, Schmidt has found iodol superior to iodoform in the treatment of large suppurating surfaces, and in fistulae. Unlike iodoform, iodol does not produce concretions on the borders of the ulcers, and thus it was seen that the healing was enhanced rapidly by the early formation of healthy granulations. Though extensively used by this author, in the form of powder and solutions locally applied to large suppurating cavities and surfaces, he has never observed symptoms of poisoning, as is of frequent occurrence in the case of iodoform.

Piermarino has reported success with the use of the drug in a large number of cases. Unhealthy granulations of the neck of the uterus, which came on as a consequence of a chronic endometritis, yielded completely to the simple application of an iodol ointment. The author cites the case of a child, four years of age, suffering from an umbilical phlegmon followed by gangrene, and by abscesses of the mammary region and suppurations of the root of the finger nails; powdered iodol, used locally, effected a radical cure. Identical results have been obtained by Piermarino in the treatment of fistula in ano, and gangrene of the vulva, when other measures had failed to do any good. A case of obstinate metrorrhagia, resulting from a chronic endometritis, was greatly benefited by the introduction into the uterine cavity of the powdered drug. These, indeed, are but few examples out of a large number of cases reported by various writers, cases in which the beneficial effects of the local use of iodol have been apparent.

Its uses, however, have not been confined to this field of action, and, as we have stated before, the agent under consideration has been employed internally with most satisfactory results. Thus, Pick, who has used it locally with decided advantage in the treatment of simple blenorrhagic catarrhs of the vagina and cervical canal, of suppurating and indurated ulcers, and other local troubles, has likewise extensively employed the drug in-

ternally. The author found that it was well tolerated by the stomach and that even in doses of from 2 to 3 grammes a day, it produced no deleterious effects, with the exception occasionally of a slight cephalalgia and looseness of the bowels, both of which, however, passed off rapidly. He also notes that its absorption is prompt and followed by the early appearance of iodine in the saliva and urine; that it was superior to iodide of potassium, especially in those cases of obstinate tertiary syphilis in which a prolonged action of the iodine is desired; and that, unlike the potassium salt, it did not produce stomatitis or nasal catarrh, even when large quantities were being eliminated by the saliva.

The same satisfactory results have been obtained by Cervesato, who more extensively, perhaps, than Pick, has employed the drug internally in a variety of diseases. The Italian writer has seen iodol do good in the various forms of scrofula, in scrofulous dermatitis, in scrofulous diseases of the mucous membranes, in the non-suppurating indolent tumors of the lymphatic glands, and others. In affections of the respiratory tract such as primary laryngeal tuberculosis, acute and chronic catarrhal laryngitis, dry suffocating catarrhs of adults, and in dry bronchitis of infancy, iodol, according to Cervesato, has exerted a beneficial influence. In three well defined cases of pleural exudation the drug enhanced absorption of the abnormal products.

Martin and Lublinski have produced cures with iodol, internally administered, in chronic pulmonary affections, and in laryngeal tuberculosis. The latter author has seen satisfactory results follow the use of iodol in ozena, especially before complete atrophy of the mucous membrane and adjacent tissues has been established. In diseases of the nose and larynx great benefit has been obtained by Seifert. This observer has used the drug with success in atrophic rhinitis and in syphilitic ulcerations of the nasal pharyngeal cavities.

The statistics published by Szadeck are similarly interesting. He has employed

cessfully, as a local application, iodoform in 20 cases of soft chancres, 10 of gummous ulcerations, and in 7 of suppurating buboes. Internally he used the medicament in 17 cases of tertiary syphilis: 4 of gummous ulcerations and tumors of the skin and subcutaneous tissue; 9 of gummata of the pharynx; 2 of syphilitic ozæna with lesions of the bones and cartilages of the nose, and 2 of syphilitic hemiplegia. All these cases were benefited, and no untoward effects were experienced by the patients. Assaky has seen beneficial results from the use of the drug not only as a disinfectant and alterative, but also as an antiseptic in cases especially of infectious disorders such as erysipelas.

In ocular practice, iodoform has been largely employed by Arago, has been especially studied by Juquer who found it of the greatest service in the following eye diseases: ulcerations of the conjunctiva; conjunctivitis accompanied with diphtheritic or purulent infiltration; primary or secondary ulcerations of the cornea; chronic affections of the lachrymal duct and suppurating dacryocystitis. Similarly good results have been obtained by Talenti, Hoffman, and Glassner in the treatment of catarrhal conjunctivitis and other eye disorders.

The same be said, according to the reports published by Shetler and Purjesz, regarding the therapeutic action of the drug in oral practice, especially in otorrhœas accompanied with caries of the osseous parts.

Stembo has found iodoform valuable in the local treatment of diphtheria. Cerna and Valdes have employed it internally with success in the treatment of diabetes mellitus.

We could cite further evidence to show the great advantages obtained from the use of iodoform in the treatment of disease, and of its evident advantages over iodine. We hope, however, that we have sufficiently impressed our readers with the great therapeutic value of this substance, and that the properties of the drug, carefully studied by the observers cited, may be taken advantage of by the general practitioner. This comparatively new remedy certainly deserves serious consideration and further trial.

We will conclude, then, by stating that iodoform may be used locally in the form of the powder itself, or as an ointment in vaseline 2 to 10 parts, and in lanoline in the strength of from 5 to 10 per cent. It may be employed similarly dissolved in alcohol of the strength of from 5 to 10 per cent., or dissolved in ether of a strength from 10 to 20 per cent. Internally, it may be administered in daily doses of from 1 to 3 grammes, for adults; in children, from 1 to 3 decigrammes a day.

BOOK REVIEWS.

SLEEP, INSOMNIA, AND HYPNOTICS. By E. P. HURD, M.D., Member of the Massachusetts Medical Society, etc. Detroit: George S. Davis, 1891. The Physician's Leisure Hour Series, Price, paper, 25 cents; cloth, 50 cents.

This number of the series was long announced to be a translation of the monograph by Germain Seé, published in the *Medicine Moderne*, but is really the product of the pen of Dr. Hurd.

In its preparation Dr. Hurd has made liberal use of the material he has published in various medical periodicals, and has given us a brochure that will fill a very acceptable place in many a physician's library. The first chapter treats of the physiology of sleep; the second of insomnia; and the third, and last, of hypnotics.

THE YEAR-BOOK OF TREATMENT FOR 1892. A Critical Review for Practitioners of Medicine and Surgery, 8vo., pp. 491. Cloth, \$1.50. Philadelphia: Lea Brothers & Co., 1892.

In this edition of this standard synopsis of the year's progress in therapeutics the reader cannot fail to be satisfied with the work done by the twenty-one eminent practitioners who compiled it. With such an epitome from year to year, the physician can keep fairly abreast of the most important advances in therapeutics.

LECTURES ON TUMORS, FROM A CLINICAL STANDPOINT. By JOHN B. HAMILTON, M.D., LL.D., Professor of Surgery and Clinical Surgery, Rush Medical College, etc. For the use of students. Second edition. Detroit: Geo. S. Davis, 1891. Price, paper, 25 cents; cloth, 50 cents.

It was but a few months ago that we had the pleasure of reviewing this little brochure, and of recommending it to those for whom it was written. The fact that a second edition is so soon called for is proof sufficient that Prof. Hamilton has supplied a want and very acceptably.

PERISCOPE.

THERAPEUTICS.

MENTHOL IN PRURIGINOUS AFFECTIONS OF THE SKIN.

Dr. W. Dubrenilk, of Bordeaux, uses menthol in all itching skin diseases with success. In urticaria, certain eczemas and in the itching following scabies after it has been cured it shows its greatest efficacy. In urticaria or pruritus without any lesion it may be employed as a ten per cent. solution in alcohol or oil. In eczema the alcoholic solutions may cause irritation, and as their action is more transient it is better to employ the solution in oil:

R^e Ol amygdalar dulc.....grams 100
Menthol..... " 6-10

Or a salve of the oxide of zinc and menthol, for example the following:

R^e Adipis } aa.....grams 25
Vaselin }
Zinci oxyd. } " 10
Menthol..... " 1-5

In case it is used upon the face, vulva, or excoriated surface, it will be necessary to lower the dose. It can, on the contrary, be elevated when the pruritis is excessive and more localized. Menthol has the advantages of being cheaper than cocaine and less odorous than peppermint essence.

ONANISM CURED BY HYPNOTIC SUGGESTION.

Dr. Bernheimer (*Revue de l'Hypnotisme*) relates an instance of cure of the habit of onanism, after the first *séance*, in a boy eight years of age, who had practised the vice for three years, and at the time hypnotic treatment was instituted admitted that he gave way to his desires as often as three or four times each night and two or three times a day. All other treatment, such as bromide of camphor, bromide of potassium, restraining apparatus, baths, special diet, intimidation, threats, etc., had failed. Suggestion during hypnotic sleep was repeated daily for a fortnight, the suggestion being that he would never again have an idea of touching himself either by day or during sleep at night, and that he would, henceforth, be strong enough to resist all temptation. From the first day there was marked general improvement, gain in weight, and entire freedom from the habit. Suggestion does not consist in an order not to do a thing, but in the confidence given to the child. It is the idea put into his brain that he would no longer succumb to the impulse.

THE ACTION OF THE CANTHARIDINATE.

Heryng describes (*Therap. Monatshefte*, November, 1891) the action of cantharidinate of potassium in twenty cases of combined pulmonary and laryngeal phthisis. There was pain after the injections, but this could generally be done away with by previously injecting a few drops of a 10 per cent. solution of cocaine. The injections were made with strict antiseptic precautions, at first between the shoulder blades, and repeated every other day. There was no inflammatory reaction or abscess at the site of puncture, but occasionally a small tender swelling appeared. Before each injection the urine was examined, and every week the body weight registered. Where there was no fever previously a rise 0.5° to 1° C. was noted in the temperature. In one case there was marked improvement in the voice, owing to the swelling allowing a more exact approximation of the cords. Expectoration was easier, but there was no diminution in the number of bacilli. The symptoms of urinary irritation, when present, were increased quantity of urine and a small quantity of albumen, with tenesmus and dysuria. They lasted a couple of days, and were relieved by opium. The details of four cases are given in full. Considerable improvement was noted in cases 1 and 3. In cases 2 and 4 the initial improvement was not maintained, one patient being lost sight of, and the other ultimately dying of his general condition. In the 16 remaining cases, 11 of which were very severe and 5 moderately so, the result was negative, the number of injections varying from three to fifteen. No positive result was obtained from any local application of the same solution to the larynx itself. Heryng agrees with other authors (1) that in early cases of laryngeal tuberculosis these injections bring about in some instances a swelling of the infiltrated parts, and a rapid cleaning of the floor of the ulcer; (2) that healing is thus favorably influenced; (3) that with 0.2 milligrammes no irritative effect is noted in the urinary system; (4) that the treatment is contra-indicated in severe cases of laryngeal tuberculosis, and also when the general condition is unfavorable, or irritative symptoms as regards the alimentary tract or kidneys are present; (5) that with doses of over 0.3 milligrammes these irritative symptoms appear; and (6) that a disadvantage of the treatment lies in a diffuse, rapidly-appearing local oedema, which increases the dysphagia. This oedema disappears of itself in a few days, but in case of out-patients it should be borne in mind.—*Brit. Med. Jour.*

ACID NITRATE OF MERCURY AS A
CAUSTIC.

Hutchinson (*Archives of Surgery*, 1891) speaks highly of this remedy as an application in nearly all unhealthy sores, and wherever an infective process seems likely to involve the other parts. It is thus useful in boils, lupus, late syphilitic disease of skin or mucous membrane, and in phagedena. It should be cautiously applied with glass brushes of various sizes, any superfluity being taken up with thick blotting paper to avoid scar-formation.

TOXIC EFFECTS OF IMPURE CHLORO-
FORM.

As an experiment on animals conducted in the Pharmacological Laboratory of the University of Berlin, DuBois-Reymond (*Brit. Med. Jour.*, No 1622, p. 209) has shown that the toxic effects of chloroform are greatly increased by the presence of impurities. By the method of Pictet, of crystallizing chloroform by means of intense cold, it was possible to separate the pure drug from impurities. The latter occasioned greater frequency of pulse, greater depression of blood-pressure, and cessation of respiration more quickly than did the former.

INTRAVENOUS SALINE INFUSION.

Dr. Pye Smith recently reported the case of a man, who had suffered from profuse hemorrhage after a severe gunshot wound of the leg. Amputation being necessary, but the patient unfit for it, a pint and a half of three-quarters per cent. saline solution was injected into his saphenous vein with marked improvement, and amputation just below the knee was performed. Circulation then failing again, another pint and a half was injected before he recovered from the ether, and at once his pulse and color were greatly improved, and in a few hours he had completely rallied, and subsequently made a good and rapid recovery.—*Medical Press*.

ANTISEPTIC PROPERTIES OF PEROXIDE
OF HYDROGEN.

Dr. Paul Gibier (*Med. News*) says:

I believe that the practitioner will meet with very satisfactory results from the use of peroxide of hydrogen, for the following reasons:

1. This chemical seems to have no injurious effect upon animal cells.

It has a very energetic destructive action upon vegetable cells-microbes.

3. It has no toxic properties; five cubic centimetres injected beneath the skin of a guinea-pig do not produce any serious result, and it is also harmless when given by the mouth.

As an immediate conclusion resulting from my experiments, my opinion is that peroxide of hydrogen should be used in the treatment of diseases caused by germs, if the microbial element is directly accessible; and it is particularly useful in the treatment of infectious diseases of the mouth and throat.

OXYGEN AND STRYCHNINE IN RESPIRA-
TORY TROUBLES.

Dr. Couper Cripps writes in the *British Medical Journal*: In view of the importance of the subject to which notice has been lately directed by Dr. Brunton and others, I would like to draw attention to an abstract of my M. D. thesis published in the *Liverpool Medico-Chirurgical Journal* for July, 1888. In this I advocated the use of oxygen for the respiratory trouble of coma in all cases, and, amongst others, related a case of opium poisoning which occurred in July, 1885, and which I treated successfully with the inhalation of oxygen, after artificial respiration had been previously maintained for over six hours without, apparently, any permanent benefit to the patient.

As regards the case of pneumonia related by Drs. Brunton and Prickett in the *British Medical Journal* for January 23d, in which venesection and the hypodermic injection of strychnine (apparently afterwards employed) failed to induce any marked effect, I may mention that in the case of opium poisoning referred to, dry cupping was resorted to over the chest and back, in order to relieve the extreme congestion of the head and neck, but it appeared to render the respiration more defective, and this was attributed to the withdrawal of blood from the circulation, diminishing its capacity for absorbing and carrying oxygen when presented to it in a dilute form.

It is thus possible that in Drs. Brunton and Prickett's case the venesection was the cause of the respiratory centre failing to respond to the hypodermic injection of strychnine, for in the following case of pneumonia a similar administration of this drug was followed by recovery:

M. B., a gentleman, aged about 42, had been going about suffering from symptoms resembling a mild attack of influenza for five days, and when first seen, on December 15th, 1890, presented signs of pneumonia,

limited to a small area outside the right nipple; this gradually extended until December 22d, when the entire upper lobe had become involved. The temperature, with slight remissions, had been about 104° F., and there had been almost constant delirium since the evening of December 15th, the mouth and the fauces were inflamed and thickly dotted over with an aphthous exudation, and on account of this and the dryness of the tongue swallowing was extremely difficult, and for the last three days nutrient enemata had been employed. The patient being thus in a critical condition, Dr. T. D. Acland kindly saw the case with me in the evening of December 22d, and gave a very gloomy prognosis. Dr. Sedgwick Saunders, who was attending from time to time in a friendly capacity, took a similar view of the case, although he was not able to be present at the consultation.

On December 24th I was called early to the patient, as it was supposed he was dying. On my arrival I found the friends firmly persuaded that the end was near at hand, one of the trained nurses having left with the impression that, such being the case, her services were no longer required. The condition of the patient was certainly alarming, for there had been several involuntary evacuations, enemata were no longer retained, there was retention of urine, and it seemed almost impossible to get him to swallow. He was quite unconscious, with teeth tightly clenched and face very dusky, constant twitching about the mouth, and convulsive movements of all the limbs. The respirations were slow and of a marked "Cheyne-Stokes" character, with long pauses at intervals, during which the patient became much cyanosed, and was on several occasions supposed, by his friends, to have breathed his last.

There being no time to obtain a supply of oxygen, which I have successfully used on other and somewhat similar occasions, I concluded the best thing to do was to stimulate, if possible, the respiratory centre, to the exhaustion of which the urgency of the symptoms appeared to be mainly due. I therefore obtained a solution of strychnine, and gave a hypodermic injection of one-fiftieth grain; a slight improvement soon took place in the breathing, and I was encouraged to repeat the injection after a short time, and at intervals of a few hours, until I had given the tenth of a grain; by this time the respiration had become quite regular, and consciousness had returned. The patient subsequently made a complete recovery.

I should mention that the case was complicated by a severe burn on the chest, caused by the application of a poultice on December 17th. This was an additional indication for the use of oxygen, could it have been obtained in time, for the gas has been shown to be of marked utility in cases of extensive burns.

DEATH FROM INJECTION OF COCAINE INTO THE TUNICA VAGINALIS TESTIS.

M. Berger (*Société de Chirurgie*, Paris, December 16, 1891) reports a case of death following an injection of cocaine into the tunica vaginalis testis for the cure of hydrocele by the injection of iodine. The patient was a young man who had a hydrocele which was very tense and as large as a turkey's egg.

As the hydrocele had developed very rapidly, M. Berger, fearing that it was a symptomatic hydrocele dependent upon some disease of the testicle, requested his interne to puncture it and examine the testicle; then, if it were found normal, to inject into the tunica vaginalis a tablespoonful of two per cent. solution of cocaine, cause it to remain a few minutes, then allow it to escape, and immediately afterwards inject the iodine, as had been done in a large number of cases without accident.

The operation was done exactly as directed. The interne injected a tablespoonful of a 11-per cent. solution of cocaine into the tunica vaginalis, left it there hardly a minute, withdrew the whole quantity injected, and proceeded to inject the iodine. The patient was not conscious of any pain; he got up after the operation, and took his leave. In a little while he returned, complained of great weakness, and at once had convulsive movements of the face and limbs, clonic and tonic convulsions, tetanic contractions of the muscles, and finally became absolutely comatose, with abundant, bloody, frothy mucus exuding between his lips; his pulse rose to 130, and he died in cardiac syncope. Injections of ether and caffeine, artificial respiration, tracheotomy, etc., were tried, but without avail.

M. Richardiére made an autopsy and found general congestion of the meninges and of the lungs, mitral insufficiency, and alcoholic lesions. The tunica vaginalis did not communicate with the peritoneal cavity. M. Richardiére had made autopsies on eleven cases where death had been due to injection of cocaine.—*L'Union Médicale*, December 22, 1891, p. 898.

MEDICINE.

NEURASTHENIA AND ITS RELATIONS TO
CHANGES OF THE GASTRO-
ENTERIC TUBE.

Dr. Champagnac has published a monograph (Steinheil, Paris) upon this subject which is very extensive, and from a bibliographic and historic point of view this question is of real and unquestionable value. His conclusions are as follows:

1. The coincidence of dilatation of the stomach and prolapse of the right kidney and neurasthenic disturbances is absolutely incontestable.

2. One may, by directing one's treatment towards the dilated stomach, cure the nervous symptoms which accompany and follow it.

3. This treatment does not cause the dilatation to disappear, but prevents the auto-intoxication which is the cause of the neurasthenic symptoms.

4. Although the gastrectasia does not disappear entirely the patient ceases to be nervous.

5. In the pathogenesis of neurasthenic disturbances, we do not admit the theory of Glénard—enteroptosis—but that of Bouchard—the pathogenic importance of dilatation of the stomach.

6. We hold the nervous theory—Beard's—as insufficient and incapable of explaining the neurasthenic phenomena, even if they have preceded the dyspeptic symptoms.—*Gazetta degli Ospitali*, No. 25, 1891.

POST PALUDAL PNEUMONIA.

Hadji-Costa (*Rev. de Méd.*, November 10th, 1891) relates fourteen cases of post-paludal pneumonia. In Thessaly malaria prevails widely and at times so severely as to merit the name of an epidemic. Such epidemics occurred in 1884 and 1885. In the two following years there was no such occurrence but numerous cases of pneumonia were observed. A relation between malaria and pneumonia undoubtedly exists. Three forms have been described: (1) The intermittent pneumonic fever of some authors in which each access of fever is said to be attended by some of the classical symptoms of pneumonia—this resembles the cases of intermittent pneumonia of non-malarial origin which have been recorded by some writers; (2) cases in which the malarial attacks occur regularly in the course of an ordinary pneumonia; and (3) cases which occur in those suffering from confirmed malarial intoxication, hence the post-paludal pneumonia. Its onset is

insidious, there is no shivering, hardly any pain in the side, and not much cough. Abdominal symptoms are frequently present—nausea, vomiting, slight jaundice, and loose stools. The temperature is intermittent, and defervescence slow; nervous symptoms often predominate. In the absence of history and physical examination of the chest, it is impossible to distinguish it from enteric fever. The prognosis is grave. The question arises as to whether the development of the pneumococcus upon a soil altered by malaria will account for the peculiar characters of the pneumonia, or whether the micro-organisms of malaria do not rather themselves bring about an inflammation of the lung unlike ordinary pneumonia. The author inclines to the latter view, and he points to analogous facts occurring in the other infective diseases. The treatment should be directed to the malaria.

A NEW VARIETY OF INTERSTITIAL
NEPHRITIS.

Dr. John Arschagouni, in an article in the *Internat. Jour. Surg.*, says: The *Bulletin de Thérapeutique* published in one of its recent numbers a new variety of interstitial nephritis, described by M. Letzerich, and due to a special bacillus, short and fine, of crescent shape found in the interstitial tissues of the kidneys, at the border of cortical and medullary substances, also in the urine of the patient.

SYMPTOMS:—Begins by an ill-defined malaise with fever and some gastric symptoms; such as anorexia, coated tongue, vomiting, great thirst, urine scanty, of a dark color, with uric acid crystals and abundant urates. This state remains from four to ten days, and after several vomitings suddenly appears oedema of the face, including the eye-lids and cheeks, also oedema of the feet, hands, and of the lumbar region, which becomes painful to touch; also some ascites, hydrothorax and even hydropericard are found. The oedema and dropsies always comes on with more or less complete suppressed urine, containing always of albumen, although less than in Bright's disease. Few renal epithelium and red globules are found and usually no casts, but, on the contrary, leucocytes and bacilli are found in great numbers.

The temperature usually does not go over more than 39.5, sometimes 40.3. In such conditions attacks of eclampsia easily could be produced in children. Often, there is somnolency, and even a comatose state. In every case there is a very intensely generalized bronchitis; alternate constipation and

more or less profuse diarrhoea. Death may close the scene by uremia towards the end of the second or beginning of the third week; but the amelioration mostly follows a free micturition, which is dark at first and gradually becomes clear. At times, especially in adults, this disease may become chronic and continue for three months. Although the differential diagnosis of this variety from other nephritis is not difficult, the microscope settles the question more surely by the presence of these special bacilli in the urine.

The prognosis is favorable. M. Letzerich, upon forty-five cases of his own observation, lost only six, others have been cured from three to six weeks in children and from three to nine weeks in adults.

M. Letzerich has been able to isolate and cultivate these characteristic bacilli and, furthermore, he has produced by inoculation in animals an interstitial nephritis. Generally, children from two to thirteen years old are most attacked, but young men from eighteen to twenty-three years old haven't escaped it. The disease mostly occurs in the hot season, probably from impure water containing these bacilli.

It would always be a wise plan in any case of early stage albuminuria, to verify if the urine freshly voided contains any such bacilli or not.

THE BACTERIUM COLI COMMUNE AND PERITONITIS FROM PERFORATION OF THE INTESTINE.

In six cases of perforation in typhoid, which occurred at Florence during the past winter, Dr. Ottone Barbaacci (*Lo Sperimentale*, August 15th, 1891) made careful observations of the peritoneal exudation. The perforation was always in the lower portion of the ileum; four times it was single, and in the other two cases two ulcers had given way close to each other. In each case cultivations were made on gelatine and nutrient agar; guinea-pigs and white rats were also inoculated with the exudation material. In four cases plate cultures were also made from the intestinal contents taken from the base of the ulcers, and also from the heart blood. In all six cases only one species of microbe developed from the cultures, and the author identifies this as the bacterium coli commune. The results of the inoculations on animals showed in three cases also the presence of the diplococcus lanceolatus capsulatus of Fränkel, but it was noted that the virulence of this was very slight, disappearing rapidly on being passed through the second animal. Very few and feeble colonies could be ob-

tained from the blood of these animals, and the author thinks that this microbe was only an accidental impurity. He regards the bacterium coli commune as the true cause of the perforation and peritonitis. He appears to have satisfied himself that it was this organism, and not the bacillus typhosus of Eberth, which was present in his cases, although, as he himself admits, the distinction between these two species is very difficult. Much evidence has lately been advanced to prove the close relations between these two bacilli; but however this may be, the results above described are of great interest, as also is another case mentioned in the same paper—in which the author withdrew by aspiration some pus from a case of suppurative perityphlitis, and obtained from it pure cultures of the same bacillus.—*Brit. Med. Jour.*

A CASE OF DISAPPEARANCE OF SUGAR FROM THE URINE.

Dr. C. G. Am Ende, makes the following note in the *N. Y. Med. Jour.*: Mrs. K., aged forty-two, mother of six children, menstruation yet regular but scantier, weight one hundred and twenty-one pounds, of good muscular development, no obesity, face flushed, was for the first time informed that she had diabetes about three years ago by Dr. —, to whom she applied for treatment of lacerated cervix with consequences, but refused operation.

In the summer of 1891 the patient came complaining of severe gastric and neuralgic disturbances. Upon examination of her urine on the occasion of her next call, Fehling's solution caused a precipitate immediately upon its addition to the yet cold urine. The specimen brought contained considerable albumen, and after a few days a copious sediment of triple phosphates, some uric acid, a quantity of pus cells and *Bacillus termo*, very few epithelial cells, the majority from the bladder, but on one slide two cohering quadrangular cells with nodules similar to the tubular; no casts. Micturition frequent, slightly painful; the right kidney swollen and painful to pressure. No urine drawn directly from the bladder. Besides intra-uterine, the treatment comprised galvanization, strict diet, bismuth, with pepsin and pancreatin, bromide of sodium, and atropine.

On October 4th no sugar could be detected; there was also a decrease of albumen. Doubting the Fehling's solution, which was over a year old, a fresh one was prepared during the week.

October 11th.—Uric acid; again no precipitate. Doubting the fresh Fehling's

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tion, the juice of a grape was added to the yet hot mixture of urine and Fehling's solution, with immediate discoloration, etc., following. Albumen reduced to faint cloudiness upon boiling with nitric acid.

18th.—Uric acid. No sugar, no albumen, kidney not painful but quite an increase in phosphates. Specific gravity had risen to 1.024 from 1.015 on October 11th. It remains to be seen whether this rise depends on a limited allowance of bread since October 11th, or a transient exaggeration of diffused neuralgias, noticed, by the way, on two other patients with hysteric affections on Saturday.

The patient reported improvement in sleep since the beginning of the month, also increasing capability for housework. Except for a small allowance of bread, rigid treatment is continuing.

THE BLOOD IN SCURVY.

In the *Centralbl. f. Bakteriologie*, September 26th, 1891, reference is made to the work of Wieruzskii, who examined the blood of scorbutic patients for micro-organisms. Cover-glass preparations were made in the first place, and examined both in the fresh state and after staining; a large number of colors was employed. No organisms were found. Next, blood from the finger and from scorbutic patches was sown upon various nutrient media, all the common and many uncommon ones being used. In all, 111 inoculations were made. Micro-organisms developed in 18 tubes only, and proved to be merely the common ones present in air, such as *sarcina* *staphylococci*, and *B. subtilis*. All the remaining tubes, both those which had been kept at the ordinary temperature and those placed in in the incubator, were found to be sterile. Finally, four rabbits were inoculated, each with several drops of blood. All remained healthy. These experiments support the view that scurvy is not a disease caused by micro-organisms in the blood.—*Brit. Med. Jour.*

(114) THE NUMBER OF LEUCOCYTES IN THE BLOOD IN PNEUMONIA.

M. Tchistovitch (*Annales de l'Institut Pasteur*, July 25th, 1891) has made some interesting observations on the cellular elements of the blood in pneumonia. It has been noted by several observers that in cases of pneumonia ending in recovery the blood generally contains a greatly increased number of leucocytes, while in fatal cases the leucocytes are diminished far below the nor-

mal number. The following experiments were made, with the object of elucidating the relation between the virulence of the diplococcus pneumoniae and changes in the number of leucocytes in the blood of animals inoculated with this microbe. Cultures were obtained by inoculating a rabbit with pneumonic sputum, and on its death inoculating tubes of bouillon with the heart blood, in which diplococci abound. These broth cultures are at first extremely virulent, but on being kept at 38° C. lose their virulence from day to day. Having thus obtained a series of cultures of different virulence, these were used to inoculate rabbits, of which the leucocytes had been carefully estimated for some days previously by means of the hæmacytometer. After inoculation the leucocytes were again counted at stated intervals until the recovery or death of the animal. The following results were obtained: 1. Attenuated cultures caused in every case an increase in the number of leucocytes, which lasted one or two days, and disappeared with the recovery of the animal. 2. With virulent cultures, after a few hours even, there was marked diminution of the leucocytes, which became more evident till death took place. (This fact had nothing to do with the enfeeblement of the circulation, since it is very early apparent, when the animal is still quite lively and has an energetic circulation.) 3. The course of the disease was dependent on the virulence of the culture and on the resistance of the animal. A culture strong enough to kill a young rabbit failed to cause the death of an older one, and produced diminished leucocytosis in the former, increased leucocytosis in the latter. Sometimes, however, the course was not quite regular, for an animal would occasionally become at first very ill with diminution in the number of its leucocytes, then these would increase and recovery take place. Although this result still requires some explanation, it would seem to be certain that a benign course is closely connected with increased phagocytosis, a fatal course being marked by absence of phagocytosis. Thus, examination of the blood in pneumonia may be important from the point of view of prognosis.—*Brit. Med. Jour.*

IRRITABLE BLADDER.

R Potassium citrate.....gr. iv.
Fluid ext. triticum repens,
Tinct. of hyocyanus.....ss ʒ j.
Fluid ext. of buchu.....ʒ ss.
Water, sufficient to makeʒ iij.
M. Sig. One teaspoonful in wineglassful of water,
three or four times daily.

—Ex.

SURGERY.

PRESENT ASPECT OF CEREBRAL SURGERY.

Dr. Landon Carter Gray in writing upon this subject in *The Alienist and Neurologist* for January, says that we do not yet know the cortical centre for temperature, pain, touch, and muscle sense. It is not always the case that the lesion is to be found on the opposite side to the paralysis; Sometimes it found on the same side. This is explained by the anatomical fact demonstrated by Flechsig, that in a small proportion of cases there is no decussation.

SPASMODIC WRY NECK.

Noble Smith F.R.C.S., Ed., in a recent publication endeavors to show that neither drugs, local applications, nor other general methods are of permanent use in the treatment of well-established wry neck. That electricity has failed to do permanent good, except in some recent cases. The nerve-stretching cannot with certainty be depended upon. That section and ablation of a piece of the spinal accessory nerve is certain to remove all spasm from the muscles supplied by that nerve, and is very likely to remove spasms set up in other muscles, although other nerves are apparently involved. That the most satisfactory plan of operation is section of the nerve upon the inner side of the sterno-mastoid before it enters the muscle. That when other muscles remain spasmodically affected, the spasms may be removed by section of the nerves supplying those muscles. That operations of section of the spinal accessory nerve, and of the posterior roots of the cervical nerves, are not followed by serious inconvenience from paralysis of the muscles. That there seems to be no risk of the reunion of the nerves, and return of the spasms after operation.

TREATMENT OF HYDROCELE.

According to the *Indian Medical Gazette*, no treatment succeeds better in ordinary cases of hydrocele than the injection of the tincture of iodine. It does, however, cause pain and may produce pyrexia, and iodism has resulted from absorption. Dr. Milliken has treated 54 cases by injection of strong carbolic acid: nine were not subsequently seen; four remained under observation, and 36 were cured; four required two injections, and five had to be injected three times. There was no sloughing, and no patient was more than a day away from business. Five to twenty-

five minims of liquefied crystals of carbolic acid are injected through the cannula which evacuated the fluid. After removing the cannula the sac is lightly kneaded to distribute the acid over its inner surface.—*Bristol Medico-chirurgical Journal*, December, 1891.

GASTROSTOMY IN STRICTURE OF THE ESOPHAGUS.

At a meeting of the Glasgow Medico-Chirurgical Society, Knox (*Glasgow Medical Journal*, 1892, xxxvii, 1) presented a man forty-eight years of age, who for seven months had had progressively increasing difficulty in swallowing and loss of flesh. On examination, a stricture of the lower portion of the esophagus, impassable to a bougie, was found. As it was feared that the obstruction would ultimately become complete, gastrostomy was performed, the stomach first being sutured to the abdominal parietes, and, after an interval of a week, incised. Not only was it an advantage to be able to successfully nourish the patient through the artificial opening, but it was found that as a result of functional rest swallowing became considerably easier.

ECHINOCCUS OF THE LIVER OPERATED ON BY COSTOTOMY.

Th. B., a young Icelandic woman, æt. 20, entered the hospital with symptoms which apparently indicated a right-sided tuberculous pleuritis, namely, infiltration of the right apex, change in the voice, sweat, failure of the general nutrition and disturbances of digestion. Examination of the sputa was not then well in vogue in that hospital. As the patient began to have rigors and grow worse, a trial puncture was made without result. In December a great prominence of the right hypochondrium and epigastrium was noticed, while the anterior border of the liver was felt three inches above the umbilicus. Friction sounds were audible on the right side of the fossa infrascapularis. December 13 a second trial puncture was made in the ninth right intercostal space and a small quantity of purulent fluid drawn off; this was examined under the microscope, but revealed nothing definite. As the diagnosis of empyæma was thought certain, the cystotomy was performed December 15, and a six centimetre piece removed from the tenth rib in the posterior axillary line. About 1,100 grains of foetid pus were removed which contained large yellowish and gelatinous masses as well as the remainder of a number of torn membranes which presented a distinct stratification and were studded with prominences of

the size of a pea. No hooks could be found. The cavity could be felt below as a funnel-shaped hole piercing the smooth surface of the diaphragm. The patient bore the operation well. The purulent discharge diminished, but the wound could not be closed on account of the discharge of bile. The prominence of the right side decreased; several calcareous masses were removed. The patient's appetite and general condition improved, although she constantly lost quite a quantity of bile. The cavity decreased in size, the fistula contracted, the drainage-tube was removed; the patient increased in weight and had naturally colored stools. The fistula finally closed entirely, and the patient was discharged as cured February 23, 1887.

The writer cites two similar cases. Firstly, that of Krause (*Sammlung Klinischer Vorträge*, v. R. v. Volkmann, No. 325, 1888), where a young man, æt. 27, presented an echinococcus cyst situated upon the upper convex surface of the liver necessitating, on account of the upward pushing of the diaphragm, the performance of costotomy and the opening of the cyst through the diaphragm. A drainage tube was inserted and the wound preserved free from irritation or infection, although a large amount of purulent fluid was discharged. Secondly, that of James Israel, (*Verhandl. d. d. Gesellschaft f. Chirurgie*, viii, 1879, 1, p. 17), which was treated after Volkmann's method, costotomy, and as it could not be determined whether the diaphragm was adherent to the tumor the wound was tamponed with carbolized gauze for seven days, and finally an incision was made into the cyst through the diaphragm.—Dr. A. Brunniche in *Hospitals-Tidende*, No. 30, 1890.

CASE OF TRAUMATIC EPILEPSY TREATED BY TREPHINING.

Dr. Alexander Mills, writes: Four and one-half years ago patient was struck on the head with a large stone, from the effects of which he could not return to work for over a week. Six months later again received an injury to his head, being struck with a bottle which cut the scalp to a considerable extent. Was not rendered unconscious. One of the cicatrices is markedly depressed. On admission there was considerable twitching of the facial muscles, retracting the angles of the mouth as if the patient was trying to say "C" distinctly. Great difficulty in protruding tongue which was quickly drawn back. No paralysis of lingual muscles, but the spasmodic action of these caused some indistinctness in articulation. These symptoms came on

about a year subsequent to his injury with the bottle. The muscles of the external ears and the occipito-frontalis contract from time to time. All his movements are exaggerated when he is watched and are suspended during sleep. Twitching movements occur at the metacarpo-phalangeal joints; there is occasional flexion or extension of the wrist joints, but never any movements of the elbow or shoulder; when standing, his toes twitch, those of the right foot especially; has dizziness and headache, which sometimes come on with vomiting; twitching of the eye-lids. Operation performed. A V-shaped incision was made over the depression on the left side, a little above and in front of the ear. On exposing the temporal muscle it was seen to be divided into two parts by a dense adherent cicatrix, which condition had simulated a depression of the skull. Trephine was applied with its centre over the cicatrix, and on removing the circle it was found to be normal, although somewhat thicker than usual. The dura mater was punctured with a small trocar and cannula and about an ounce of clear fluid drawn off. The dura did not bulge; it was thickened at one part. The vessels on its surface were then secured with double ligatures and divided, and a crucial incision was made into it. This exposed a bluish translucent cyst wall with a large vein coursing across it. There was a depression on the surface of the brain which measured about half an inch in every direction, but the brain tissue seemed healthy. The bone was not replaced. Wound dressed with iodoform gauze. After recovery from the effects of the chloroform jerking movements went on as before, affecting his tongue very much and making his articulation indistinct. Patient was difficult to manage. Remained in this condition for several days, being given chloralamid and hyoscine to keep him quiet. In a few days could speak a little better; spasms not so constant. Jerkings were much marked during sleep and also when greatly excited. About a month after the operation patient went home under the care of his brother. Was afterwards admitted to insane hospital, as he was somewhat dangerous and had threatened to kill his brother. He says this case is interesting in view of the fact that, although a distinct pathological lesion was found, and so far as could be, removed, no marked improvement took place in the condition of the patient. He says that it is possible that the pressure of the cyst had damaged the centres over which it was placed beyond the point from which they could recover.—*The Lancet*, Nov. 28, 1891.

OBSTETRICS.

INDUCTION OF PREMATURE LABOR BY GLYCERINE INJECTIONS.

Pelzer (*Centralbl. f. Gynäk.*, No. 2, 1892) gave a very satisfactory account of his experience of this method. He employs chemically pure, sterilized glycerine. A hundred cubic centimetres are thrown up between the membranes and the uterine wall. Full precautions are taken, not only against sepsis, but also against the entrance of air into the uterine cavity. In a short time regular pains set in. The membranes present well, and labor is usually easy. In two cases where labor was induced on account of contracted pelvis, the pains set in, in the first case, within half an hour, in the second after an hour. In a third case, the patient was at the end of the thirty-second week of pregnancy. For fourteen days she had been flooding; there was placenta prævia lateralis and a temperature of 104°. Glycerine was injected and pains set in an hour and a-half. Bleeding occurred two and a-half hours later. Turning was performed, and a dead child was delivered. The mother recovered. Glycerine injections are, in Pelzer's experience, valuable not only for the induction of premature labor, but also for accelerating delivery at term. In uterine atony it proves very efficacious.

RENEWAL OF MENSTRUATION AND SUBSEQUENT PREGNANCY AFTER REMOVAL OF BOTH OVARIES.

J. Anderson Robertson performed extirpation of both ovaries for cystic disease of these organs in a girl 23 years old. Three months after the operation she began again to menstruate. Five months after the operation she was married, became pregnant, and was delivered of a strong and perfectly healthy male child on October 25, 1890.

"From this very interesting case we may," says the author, "I think, learn several lessons. Amongst these are:

"(1) The truth of Mr. Lawson Tait's teaching regarding the starting point of menstruation—namely, that the ovaries are not causative of it. In fact, in this case, the presence of the diseased ovaries prevented it; normal menstruation was interrupted and the patient suffered from vicarious menstruation, as nose-bleeding, hæmoptysis, etc., and when they were removed normal menstruation followed.

"(2) The possibility of vicarious menstruation. The woman had brought up blood daily for months, but this ceased after the removal of the ovaries—that is, when normal

menstruation became possible—and it has not recurred.

"(3) The proof that removal of both ovaries does not necessarily render a woman impotent. (An interesting medico-legal discussion might be raised on this point.) I was not aware of leaving any ovarian tissue. Indeed, my aim was to extirpate the ovaries thoroughly, and I thought I had done so. I suspect, however, that a small portion of healthy ovarian tissue had reached up to or beyond the hilus of the right ovary, and that this may have taken on regular ovarian functions. This, of course, is merely conjecture.

"(4) That in performing double oophorectomy, except in cases of uterine fibroid, any apparently healthy portion may, perhaps, be left. I shall, at all events, keep this in mind in future operations."

NITRIC ACID AND CRIMINAL ABORTION.

Bellin, of Charkoff (*Nouvelles Arch. d'Obstét. et de Gynec.*, October, 1891, Supplement, p. 456), read before a medical society in that city a remarkable paper on eight cases of nitric acid drinking to produce abortion. The subjects took at first from fifteen to twenty drops of the acid several times a day, gradually increasing the dose. Severe symptoms appeared at the end of a month or six weeks. Abdominal pains, nausea, vomiting, constipation and subnormal temperature were observed, with remarkable mental symptoms. The patients also grew thin. In the first case abortion took place at the third month, and the patient was cured. In the second, abortion occurred at the same stage; the patient suffered miserably from abdominal pains afterwards, and ultimately killed herself. The third patient became insane. The fourth aborted at the fourth month and recovered. The fifth did not abort and recovered. The sixth committed suicide by swallowing matches, owing to the intense pain from which she suffered. Abortion occurred on the day before death. The seventh patient took the acid for two months without abortion occurring; she was syphilitic. The eighth, also subject to syphilis, took nitric acid for five weeks during the second and third months of pregnancy. She was delivered of a macerated fetus on the sixth month and became insane. In all these cases where abortion occurred, it happened when the poisonous effects of the acid were most marked, or later after they had been counteracted. Bellin believes that the pathological changes caused by nitric acid depend upon the influence of that acid on the composition of the blood.—*Brit. Med. Jour.*

April 23, 1892.

Periscope.

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GYNÆCOLOGY.

MENTHOL IN PRURITIS VULVÆ.

Dr. Saalfeld, of Berlin, has found menthol, in a three to six per cent. alcoholic solution, to be more efficacious in this affection than either carbolic or salicylic acid solutions. He also obtained good results from a menthol-lanolin salve.—*Verhandlungen d. Dermatol. Vereinig., zu Berlin, 1891.*

OVULATION WITHOUT MENSTRUATION:
PREGNANCY.

Loviot (*Arch. de Tocol. et de Gynéc.*, January, 1892) related, at a recent meeting of the Paris Obstetrical and Gynecological Society, the case of a woman who had not seen a monthly period for fourteen months. Rheumatic pains set in and the abdomen became swollen. He discovered pregnancy between the sixth and seventh month. The mother did not believe in this diagnosis; nevertheless she was afterwards delivered of a very small child.—*Brit. Med. Jour.*

PRIMARY FIBROSARCOMA OF THE NASAL
FOSSÆ.

Cineros, of Madrid, (*Arch. Int. de Rino-logia*, etc., February, 1892) records the case of a man, aged 46, who had suffered for about a year from gradually increasing obstruction of the left nasal passage, with profuse mucopurulent discharge and frequent hæmorrhage. On examination, the left fossa was found completely filled by a greyish mass with granular surface, painful, friable, and bleeding at the slightest touch. Posterior rhinoscopy showed vegetations of the growth projecting through the left choana. Examination with a probe showed that the tumor had a pedicle and that it sprang from the cartilaginous part of the septum. The mass was removed with the galvano-caustic loop, but immediately showed signs of recurrence. Vigorous use of forceps and cautery being insufficient to check the process, an incision was carried round the left ala, and, free access being thus obtained to the nasal fossa, tumor was removed as thoroughly as possible, the site of implantation being scraped with Volkmann's spoons and all suspicious points touched with the galvano-cautery; the fossa having been washed out and stuffed with iodoform gauze, the ala was replaced in position and sutured, the patient leaving the hospital on the seventh day. A fortnight later the growth had again recurred, this time perforating the septum and appearing in the right fossa. Forceps and cautery

having again failed to stay the progress of the disease, both posterior nares were tamponed and the whole growth cleared out under chloroform with forceps and sharp spoons, nearly the whole of the cartilaginous septum being removed in the process. When seen a year later there was no sign of recurrence. The growth was examined by Dr. Mendoza, chief of the laboratory of the Hospital San Juan de Dios and pronounced to be a fibrosarcoma.—*Brit. Med. Jour.*

SCARIFICATION OF THE OS UTERI IN
CHLOROSIS.

Dr. J. Cheron recommends scarification of the os uteri in chlorosis, and points out that this treatment has been highly spoken of by Schubert and other. The amount of blood to be drawn is about one gramme to every kilogramme of body weight. According to the above observers these slight bleedings greatly increase the number of red corpuscles and the amount of hæmoglobin in the blood. Dr. Cheron, in making use of scarification of the os in the treatment of old-standing disease in chlorotic patients, found that the general health as well as the local conditions improved. In many cases an analysis of the blood during and after treatment showed continuous improvement after each scarification. In chlorotic patients congestion of the womb is habitual, and it is easy to obtain forty to sixty grammes of blood at one operation. This local treatment seems likely to be of great benefit to chlorotic women, and it is easy to understand that it would be performed much more readily than venesection. The scarification, if done with antiseptic precautions, is not accompanied by risk.—*Lancet.*

A SENSITIVE TEST FOR ALBUMEN IN
URINE.

The reagent is made by dissolving 8.0 mercuric chloride, 4.0 tartaric acid, 20.0 sugar in 200.0 water; the acid is added to produce a strongly acid solution and the sugar to increase its density. In applying the test the urine is acidulated with a few drops of strong acetic acid, filtered and delivered by means of a pipette into a tube half-filled with the reagent so as to form two layers. If the urine contains even less albumen than 1 in 50,000, there is produced immediately or before the lapse of a minute, a distinct white ring at the line of contact; the white ring is especially seen if the tube is held against a black background.—Dr. E. Spiegler, *Oesterr. Zschr. f. Pharm.*, 1892, 65.

PÆDIATRICS.

PROPHYLAXIS OF SCARLATINOUS NEPHRITIS.

Dr. Ziegler (*La Semaine Médicale*, No. 4, 1892) puts his scarlatina patients upon a milk diet from the very first, and in over a hundred cases he has not seen a renal complication. During the first few days, when the anorexia is complete, the child is given a little milk, diluted with mineral water, when the appetite returns the child is given from a pint to three quarts of milk a day for the first three weeks, the milk is first boiled before administering. Now and then the child may be permitted to eat a piece of bread or a biscuit. This is continued in all its strictness for the first three weeks of the disease, to return gradually to the ordinary food.

EPIDEMIC OF CONTAGIOUS PORRIGO IN INFANTS.

Jonathan Hutchinson gives an interesting account of an epidemic of contagious porrigo (impetigo contagiosa) occurring in infants born in the maternity ward of St. Pancras Workhouse, England. The starting of the epidemic seems to have been due to vaccination, but afterward no connection could be traced with the vaccine virus. The eruption was bullous, non-symmetrical, easily curable, of a local character, and with but little constitutional disturbance. It was decided that the wards should be closed for a month, and every possible means of disinfection should be employed. This was done; but on again opening the wards, after several children had been born and discharged healthy, the eruption again broke out. Several of the mothers contracted the disease, and it appeared on them as an impetiginoid eczema.—*Archives of Surgery*, January, 1892,

EXALGIN IN CHOREA.

Lowenthal (*Berl. Klin. Wochenschr.*, 1892, No. 5, p. 95), reports the results of the employment of exalgin in the treatment of thirty-five cases of chorea. Three grains were given three times daily; in a few cases the dose was given five times daily; in one case a grain and a half were given daily. The patients ranged from three to eighteen years of age. These cases presented all degrees of severity. The results were, on the whole, satisfactory; recovery was speedy in mild cases, retarded in severe cases. The duration of treatment was from a week

to eight months. The results were the better the earlier in the disease the cases were seen. Unpleasant symptoms, such as tinnitus aurium, a sense of intoxication, disturbances of vision, vertigo, nausea, vomiting, jaundice, increased pain, headache, and cyanosis were observed in some cases in which the largest doses were employed; but these manifestations ceased upon the withdrawal of the remedy. It seemed as though a certain degree of tolerance of the remedy developed.

THE TEMPERATURE IN ACUTE PRIMARY PNEUMONIA IN CHILDREN.

As the result of a study of this subject, Holt, (*Archives of Pediatrics* 1891, No. 12) makes the following summary:

1. The predominating type of temperature in acute primary broncho-pneumonia is high and remittent, the daily fluctuations amounting usually to from three to five degrees Fahr. The sustained high temperature is uncommon except in the rapidly fatal cases. A low range of temperature—only two or three degrees above the normal—is not very uncommon, but is more frequent in fatal cases.

2. The termination of the fever is almost invariably by lysis.

3. The lowest mortality is among cases in which the fever lasts from eight to fourteen days; the highest is among those lasting but two or three days; the next to these the protracted cases, lasting over four weeks.

4. The day of highest temperature in fatal cases is usually the last day; in recovery cases there is no rule in this respect.

5. The lowest mortality is seen in the cases in which the highest point reached was between 103° and 104.5° F. Above 105° the mortality rises with the increase of each degree in the temperature. Abnormally low temperature are also to be dreaded, since they usually indicate a constitutional condition which makes recovery very doubtful.

TWO CASES OF HYSTERIA IN CHILDREN.

Dr. A. Selmer, of Balsfjorden, Norway, records two cases of hysteria in children which came under his observation. The first case was that of a 13-year-old girl of phthisical antecedents, who had overworked herself at school. She presented the characteristic picture, with maniacal attacks at times. She eventually recovered under electrotherapeutic treatment. In the second case, a girl of 10, the disease began under the guise of a febrile state resembling typhoid fever, together with a peculiar apathetic condition.

This continued for four weeks. She would then lie in an apathetic state with eyes closed, refuse to answer, and reject nourishment. By careful watching, it was found that she arose of nights and ate plentifully. This was kept up for seven months.—(*Norsk. Magazin for Lægevidenskaben*, No. 6, 1891.)

HYGIENE.

AN IMMUNITY-CONFERRING PRINCIPLE IN THE BLOOD OF ANIMALS TREATED WITH TUBERCULIN.

Having observed some degree of immunity in tuberculous guinea-pigs treated with tuberculin, Tizzoni and Centanni (*Centralbl. f. Bakteriologie u. Parasitenk.*, xi, 3 u. 4, p. 82) preceded injections of suspensions of tubercle bacilli into the jugular vein by the introduction of the serum of the blood of such animals into the peritoneal cavity. Of ten animals thus treated, five died. All presented local lesions at the site of inoculation. In the fatal cases death was deferred and the visceral lesions were less extensive than usual. The view is expressed that tuberculin is, or the soluble products of the tubercle bacillus are, capable of conferring a certain degree of immunity dependent upon the presence of an active agent in the blood, and that the good effects of tuberculin do not result from a direct action, but are dependent upon the generation in the body of some protective principle, which it is hoped future investigations will succeed in isolating.—*News*.

ANCIENT HINDU VACCINATION.

At a meeting of the Epidemiological Society (*Lancet*, February, 29, 1892), Dr. Pringle quoted a remarkable passage from an ancient Hindu work, which showed that true vaccination was known and practised in India centuries before the birth of Jenner: "The small-pox produced from the udder of the cow will be of the same mild nature as the original disease. . . . the pock should be of a good color, filled with a clear liquid, and surrounded by a circle of red. . . . There will be only slight fever of one, two or three days, but no fear need be entertained of small-pox so long as life endures." Pasteur's attenuation of virus by successive cultures has been applied in India for hundreds of years to inoculations with variolous lymph, which the document in question directed to be taken from "the most favorable cases," and he has seen series of such selected inoculations in which there was no general eruption,

and the local phenomena were scarcely distinguishable from those of vaccination

INFANT MORTALITY IN FRANCE.

At a recent meeting of the Society for the Protection of Children in France Dr. Rochard (Chairman) stated that France loses every year 250,000 infants, and that out of this number there are at least 100,000 whose lives could be saved with intelligent care. These lives were the more precious in the present period, for France could no longer afford to lose them. When he stated, in 1884, that the population of France would stop increasing towards the beginning of the 20th century, he was pooh-poohed. His prophecy has been justified sooner than he wished. The number of deaths in 1890 outnumbered the births by 38,446. It was not easy, said Dr. Rochard, to add to the births, but it was possible to diminish the death-rate among infants. The 100,000 babes that ought to be saved every year would repopulate France. He then distributed medals and prizes awarded by the Society to doctors and nurses who had given their services to the Society.

PREMATURE BALDNESS AND ITS CAUSES.

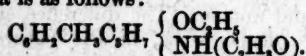
Dr. Tyson's recent contribution to our pages on premature baldness, its causes and prevention, expresses the views that there is an increasing prevalence of premature baldness in men as compared with women, and that the cause is that men habitually wear heavier and more complete covering than women. We are not aware of any facts being adduced beyond Dr. Tyson's own impressions that premature baldness is more prevalent than formerly, and even if it were so we should still dispute his argument that the cause lies in the different character of the headgear of men and women. The difference, such as it is, lies deeper—viz., in the natural differences in the constitution of men and women as regards hair growth, and one element among these probably is the greater thickness and superior vascularity of the scalp in women as compared with men. Certainly the positions in which baldness first develops—viz., the upper part of the occiput, the vertex, and the temples—are all situations where the scalp is thinner than elsewhere; the sides of the scalp, for instance, which rarely become denuded of hair in what may be termed normal baldness. Indeed, the bald man seeks here the means to conceal his loss somewhat, and, by parting his hair immediately over his ear, and training what can thus be separated over the vertex, hopes that what he regards

as his defect may escape notice. Here we may remark that women lose their hair more frequently than is generally supposed, but are, from the arrangement and length of their coiffure, more successful than men in concealing it, and, if necessary, replacing the deficiency, while any such substitution by a man is like a town-crier proclaiming his loss to all beholders. Again, if the constant and more complete covering of the head were really the cause of baldness, it ought to be much more prevalent among the working classes, a large proportion of whom wear their hats or caps from morning till night; but few would venture to say that a larger proportion of them were bald than of those whose occupation employed the head more than the hands. Dr. Tyson's remarks on the general management of the hair seem to us sensible and sound as far as they go, but the addition of some form of antiseptic to the grease he recommends for occasional use would help materially in warding off that most frequent cause of baldness—seborrhœa capitis. When, however, the baldness exists as an hereditary failing, our efforts have to be confined to palliative treatment, directed towards delaying the process.—*Lancet*.

MEDICAL CHEMISTRY.

THYMACETINE.

At a meeting of the Berlin Gesellschaft für Psychiatrie und Nervenheilkunde on December 14th, 1891, Jolly gave an account of his experience with thymacetine, a substance prepared by Hoffmann, of Leipzig, which bears the same relation to thymol that phenacetine bears to phenol. Its chemical formula is as follows:



It is a white crystalline powder, slightly soluble in water. Little is at present known about it from the pharmacological point of view beyond the fact that in two-gramme doses it does not cause toxic symptoms in dogs. Jolly was unable to test its antipyretic action, owing to the small quantity of the substance at his disposal. He found, however, that it had some effect as an analgesic. In seven cases of true migraine, thymacetine did no good, although the dose was progressively increased from 25 centigrammes to 1 gramme; but in other forms of headache it gave just as much relief as phenacetine. It has also some efficacy as a hypnotic. It was given in 26 cases of paralysis, delirium, etc., with insomnia, and in 16 it induced quiet

sleep; in the remaining 10 the effect was nil. In patients who were in the habit of taking chloral, thymacetine appeared to produce just the same effect as that drug. The average dose required to induce sleep was 50 centigrammes. Among the secondary effects noted was acceleration of the pulse, the patients at the same time complaining of fullness, beating and noises in the head. Jolly thinks further trial is needed to prove the therapeutic value of thymacetine.—*Brit. Med. Jour*.

SALICYLIC ACID REACTION.

According to Schneegans and Gerock, the violet color resulting from the mixture of 10 cc. of a 0.2 per cent. solution of salicylic aldehyde with 2 cc. of a very dilute solution of perchloride of iron may be removed by shaking with 5 cc. of chloroform or ether. But if only 0.002 gm. of salicylic acid be added, the violet color remains persistent. A similar reaction occurs with the methyl ether of salicylic acid, and it may be used to detect as little as 1 part in 500 of free acid in artificial oil of wintergreen.—*J. Pharm. Elat. Loth. and Ph. Journ.*

MICROBES OF THE DEAD SEA.

For a long time there was doubt as to whether any organism, animal or vegetable, lived in the Dead Sea. Now the question is solved by a patient Frenchman, Dr. Lortet, who finds at last, in water from the Dead Sea, specific microbes of gangrene and tetanus. Inoculated rabbits promptly expire, which proves that the classic *Lacus Asphalites* is more alive than was formerly supposed.—*Ex.*

NITROUS ETHER AND ASTRINGENT DRUGS.

The probable cause of the evolution of gas in mixtures containing spirit of nitrous ether and fluid extract of uva ursi has been a fruitful theme in pharmaceutical literature these many years, and while the tannin of the uva ursi was by general consent asserted to be the exciting agent, no definite experiments were ever instituted to settle the question. The first step in this direction, so far as the writer is aware, has been taken by Mr. Leon C. Fink, who (*Notes on New Rem.*) experimented not alone with the effect of spirit of nitrous ether on various drugs containing an astringent principle as well as such in which no tannin is present, but he also employed tannin and gallic acid themselves. These experiments, some forty in number, have conclusively shown that tannin in contact with

nitrous ether is decomposed with the simultaneous disengagement of nitrous fumes, and this irrespective of whether the nitrous ether employed has an acid or neutral reaction. The nature of the reaction was not inquired into.

URINE TOXICITY IN THE INSANE.

Dr. Mairat and Bosc (*Jour. des Sociétés Scient.*, Nov. 11, 1891) state that in quiet mania urinary toxicity is the same as in the sane. In agitated mania the degree of toxicity is greater. In stuporous insanity the toxicity is less than in normal urine. In melancholia with stupor the urine was much more toxic and had toxic peculiarities. In melancholia the toxicity was increased in proportion as the anxiety increased. The urine had the same toxic qualities so far as regards myosis, micturition, the alimentary canal, and the circulation, but differed in the following particulars: Variations in temperature were produced. Hypothermy was first produced followed by hyperthermy, which was followed by a fall in temperature; sensibility abolition; diminution of reflexes; psychomotor disturbances, abulia, inquietude depression, anxiety, and auditory hyperaesthesia. In persecutory delusional cases toxicity is slightly greater than in normal urine. In senile insanity toxicity is less than in the urine of sanity. The urines of the insane may be grouped into two classes. (1) Those whose toxicity is not greater than the normal (senile insanity, calm period of certain psychoses). (2) Those whose toxicity is greater than normal. These last may be divided into two sub-groups: (A) Those in which the toxicity is more or less due to agitation or depression of the psychosis. (B) Those in which urinary toxicity persists independently of agitation or depression (melancholia with stupor, and certain manias). The toxic qualities of the urine of the insane are similar to those of normal urine so far as the alimentary canal, respiration, circulation, micturition, temperature, and even the nervous system are concerned. They may, however, so far as the nervous system is concerned, be divided into two groups. (1) Those in which symptoms due to normal urine are exaggerated. (2) Those in which symptoms are not produced by normal urine result. The first group includes certain cases of mania, and stuporous insanity. The second, certain cases of mania, melancholia with stupor, and melancholia. In cases where pathological urine merely reproduces the toxic tableau of normal urine, the degree of toxicity is due to an intensity more or less considerable of the

disease, to agitation in mania, and depression in stupor when pathological urine gives rise to new toxic symptoms. These are due to the disorder itself. From this it results that by the side of psychoses produced by neurotic causes must be placed psychoses produced by disordered nutrition.

NEWS AND MISCELLANY.

DOCTOR—I believe you have some sort of poison in your system.

PATIENT—Shouldn't wonder. What was that stuff you gave me?—*New York Weekly.*

A California physician, not strictly ethical, advertises to pay half the funeral expenses in all cases where he is not successful. Probably he practices the "kill or cure" system.

MISSISSIPPI VALLEY MEDICAL ASSOCIATION.

Members of the Mississippi Valley Medical Association wishing to go to the American Medical Association at Detroit as delegates, will please send their names to

DR. E. S. McKEE, Sec.,
57 W. 7th St.,
Cincinnati.

A RIGOROUS EXPERIMENT.

Interesting and perhaps important in point of utility, an experiment lately carried out in the Russian army must come dangerously near to censure if tried in the light of humanitarian principles. In order to ascertain whether tents would suffice to shelter troops in the field during severe winter weather, eight soldiers chosen at random were, it is stated, made to pass the night, or as much of it as they could endure, under such conditions. Every care seems to have been taken to provide these men with warm and heavy clothing, and the snow within the tent was beaten down and covered with mats and straw. The men slept comfortably from nine in the evening until nearly four next morning, at which hour the thermometer showed that the temperature, originally registered as 31° F., had fallen to 4° below zero, within as well as outside the tent. Nature could them endure no more; sleep was impossible, and the soldiers only saved themselves from freezing by taking exercise in the open air. Everyone can understand the bearing of such observations on practical warfare, and we would not lightly disparage their useful intention. Nevertheless, it is

something new to find the human species thus subjected to such an *experimentum in corpore vili*, and we sincerely hope that military necessity will not—as we believe it should not—call for its repetition. The recorded experience of Arctic voyagers—who have often camped out in tents—may surely now suffice for evidence as to the amount and quality of clothing and of tent appliances required to withstand the extremes of winter cold.—*Lancet*.

PHILADELPHIA POLYCLINIC HOSPITAL.

An examination for the position of two Internes and two Externes in the Hospital of the Philadelphia Polyclinic, will be held May 3, 1892. The Committee will meet and examine the candidates on the date named above, at 8 P. M., in the hospital building, Lombard Street west of Eighteenth.

A number of clinical assistants will be appointed. Those desiring to apply should present their claims to the Committee.

G. E. DE SCHWEINITZ, M. D.,
H. AUGUST WILSON, M. D.,
S. SOLIS-COHEN, M. D.,
T. S. K. MORTON, M. D.,
Harris A. SLOCUM, M. D.

REMOVAL OF OVARIES FOR MOLLITIES OSSIIUM IN NON-PUERPERAL WOMEN.

W. Thorn (*Centralb. f. Gynak.*, October 10, 1891) has observed two cases of mollities ossium. The first was in an early stage of the disease. She was still under treatment with iron, arsenic, and phosphorus, but without effect. In the second case the ovaries were removed. The patient was 32 years old, and had married in 1885. She bore three children, the last being born eleven months before the operation. After the birth of the second child the characteristic symptoms of mollities appeared, and increased during the third pregnancy, where labor was lingering and delivery completed by forceps. The disease afterward made rapid progress and caused great distress; the patient could not sleep owing to severe pain in the bones; the sternum was very tender to touch, and pulmonary symptoms set in. The case was much complicated by perimetritis. On November 9, 1891, the appendages were removed. The operation proved difficult for two reasons; the uterus was retroflexed and adherent; the pelvic cavity had become very narrow so that the necessary manipulations were difficult; the

separated adhesions bled freely. The second complication was remarkable. The connective tissue of the pelvis was extremely oedematous, as seen normally in the puerperium alone; hence ligatures applied to the bleeding vessels on the uterine adhesions gave way, and the left tube was completely cut through when its ligature was being pulled tight. Thorn directs attention to this condition of the pelvic connective tissue, and asks if it be characteristic of mollities. After the operation, the pains in the bones rapidly disappeared, the sternum ceased to be tender to touch by the third day. On the fifth day uterine hæmorrhage took place, the temperature rose over 102° F., but soon fell to normal; the bronchial catarrh ceased, and the patient's general health became excellent. A show of blood occurred two months after the operation. The patient was then able to walk, though she waddled on account of the great changes in the pelvis and lower extremities. The disease was clearly arrested. Thorn is of Fehling's opinion, that mollities is an endemic reflex trophoneurosis of the bones, dependent upon the function of the ovaries, and that the removal of the ovaries is indicated as a cure for that disease.—*Brit. Med. Jour.*

TEST OF HYDROGEN PEROXIDE.

When a drop of a 10-per-cent. solution of metaphenylene-diamine chloride is boiled with a few drops of water and a drop of hydrogen peroxide solution, a carmine-red coloration is produced. This reaction will detect 0.005 mgm. of hydrogen peroxide in a drop of water, but is affected by the presence of nitrites. The test is thus modified, to be independent of the presence of the latter compounds: One or two drops of metaphenylene-diamine chloride are added to 1 cc. of ammonia solution containing a few drops of hydrogen peroxide solution. The mixture is boiled for some minutes, when the previously colorless solution becomes blue, of intensity corresponding with the peroxide present. Addition of alkali hydroxide solution changes the color to red.—G. Denigès in *Bull. Soc. Chem. and Jour. Chem. Soc.*

SEAT WORMS.

Tincture rhel.....gtt. xix.
Magnesia carbonatss. ij.
Tincture singiberis.....gtt. ij.
Aqua, q. s.....ad 5 iv.

M. Sig. Warm and use as injection three times daily.

—*Memphis Med. Monthly*